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IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

THURSDAY 22 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 9.12AM

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HER HONOUR: Good morning. Dr Dwyer.

DWYER: Morning, your Honour. Your Honour will see that we have our panel of expert psychiatrists assembled this morning, and we'll swear them in, starting with Professor Nordentoft. I just note that Professor Nordentoft is coming to us online. I'll just check that the professor can hear us?

NORDENTOFT: I can hear you.

HER HONOUR: Good morning, Professor Nordentoft.

DWYER: Might I also note how grateful we are for Professor Nordentoft coming to us at what is 1am her time, so she is essentially pulling an all-nighter to be with us today on screen for the remainder of the time today. I think she's available until 2.30pm today, which is all night her time, or morning.

HER HONOUR: Professor Nordentoft, we're most grateful that you've made yourself available at this very inconvenient hour for you. And I must say I'm grateful to all of our experts. I know it's been a very short turnaround time for all of the reports that you've prepared, and I thank you in anticipation and already for your assistance in this inquest.

DWYER: I just note for the record, your Honour, the panel are Professor Merete Nordentoft, Professor Edward Heffernan, Professor Anthony Harris, Professor Olav Nielssen, and Professor Matthew Large. I call the psychiatric panel and ask that they be sworn in.

HER HONOUR: Thank you.

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<MERETE NORDENTOFT, OLAV NIELSSEN AND MATTHEW LARGE, AFFIRMED, EDWARD HEFFERNAN AND ANTHONY HARRIS, SWORN(9.14AM)

ROBB: Your Honour, if I might raise briefly one matter?

HER HONOUR: Yes.

ROBB: I would seek leave this morning to appear on behalf of Dr John Reilly, who is the Chief Psychiatrist of Queensland. Dr Reilly has a statutory mandate to assist and promote an understanding of the Mental Health Act in Queensland, and he has made himself available to watch today's evidence and will intend to furnish a statement as soon as possible, just assisting in relation to the legislation in Queensland, and will make himself available if anyone wishes to examine him in the first half of next week.

HER HONOUR: Certainly, thank you, Ms Robb. Leave is granted and I'm grateful to Dr Reilly.

ROBB: Thank you, your Honour.

HER HONOUR: Dr Dwyer.

DWYER: Your Honour, might I just spend some time firstly to go through some of the qualifications, particularly because this panel is being recorded and there is significant interest in the community in the qualifications and opinions of each of the psychiatrists.

Starting with you, Professor Nordentoft, you have kindly provided an expert report which appears at tab 14 of our bundle. You prepared that expert report at the request of the Crown Solicitor's Office to assist her Honour. You note in that some of your background and experience. I won't be able to do it justice - as is the case for each of our five panel members - but you're a Professor of Psychiatry at the Department of Clinical Medicine, University of Copenhagen, is that correct?

WITNESS NORDENTOFT: Yes, please.

DWYER: You are the director of research at the Copenhagen Research Centre for Mental Health, otherwise known as CORE. What is that service?

WITNESS NORDENTOFT: It's a, a research centre based at the mental health services in Copenhagen - in the Centre for Mental Health Services at Copenhagen. It's a large research unit consisting of 50 people, many of them who have worked with patients with schizophrenia, both with regard to trying out different, primarily psychosocial intervention, but also register-based studies and long-term follow-up studies of cohorts. So, I have had, through that work, insight in long-term prognosis for schizophrenia, and also the proportion who are able to discontinue medication without relapses and also different adverse events in, in patients with schizophrenia.

DWYER: On that topic, we note in your background that you have had extensive clinical experience with disorders within the schizophrenia spectrum, and you've conducted 250 interviews using the schedules for clinical assessment in neuropsychiatry. You are one of two certified World Health Organisation experts in SCAN - that is, the Schedule for Clinical Assessment in Neuropsychiatry - one of two WHO experts in Denmark. What is SCAN?

WITNESS NORDENTOFT: SCAN is an extensive diagnostic interview which is developed in the WHO, and it's used in countries all over the world. And in each of the countries, there are people responsible for being experts in, in those diagnostic interviews and providing training courses, treatment and assessment of the - of interviews.

DWYER: Within your background it notes that you have significant experience in assessing homeless individuals. You've interviewed 160 homeless people living in shelters or on the streets in relation to their mental illness. Could you tell her Honour about that study?

WITNESS NORDENTOFT: Yes, it, it is a long time ago. It was in the 1990s. But I did interview - I led a study where we interviewed 200 homeless people in shelters. I did a hundred of these interviews, and then I also did a study with 59 people on the street where I, I did also interviews. And it was interviews with regard to their life history, the background for their - for homelessness, and also diagnostic interviews.

DWYER: We'll return to the issue of homelessness in relation to Joel Cauchi and the possible impact of homelessness and what has been written about that previously by Professor Large and Professor Nielssen. But could you tell us what the conclusions of that study were?

WITNESS NORDENTOFT: Well, what I found out was that a large proportion of the homeless people, both in the street and in the shelters, suffered from mental illnesses. And the - in, in the street, it was rather severe mental illness, many had schizophrenia not being treated for many years, and they, they had very - yeah, it was very severe form of schizophrenia. In the shelters there were also many cases with severe schizophrenia and substance abuse, and those who had contact with the mental health services, they had it mainly because they were forensic patients. Very few had contact with mental health services on their own initiative.

DWYER: Was there a conclusion reached that there was a link between schizophrenia and homelessness and vice versa? So, did schizophrenia often cause homelessness and did homelessness exacerbate the symptoms of schizophrenia?

WITNESS NORDENTOFT: Yes, I think I can say yes to both. Definitely schizophrenia could cause homelessness or could contribute to the development of homelessness. For some of the people it was their delusional experiences that led them to leave their houses or to believe that they paid the

rent by non-existing satellite or things like that. So they were - they, they had definitely schizophrenia, and the symptoms associated with schizophrenia had led to homelessness for some of - for a large proportion of these people. And on the other hand, I think that homelessness also contributed to exacerbating schizophrenia. It was not homelessness that caused schizophrenia. I don't think I could state that.

DWYER: Did it flow from those findings that it was important to provide appropriate supported accommodation for people with schizophrenia?

WITNESS NORDENTOFT: Could you repeat that?

DWYER: Certainly. Did it flow from those findings that it was important to the people of Denmark to provide supported accommodation for people with schizophrenia to prevent the worsening of symptoms, or to manage the disease?

WITNESS NORDENTOFT: Yeah, I, I think, I think that of course it was a small drop. You know, the contribution from these studies were not at that time very influential. I was also a very young doctor. But, but I think it played a role, and it has since, other people have done similar. Also people in my group who have done register-based studies where we could see the - all the disadvantages of being homeless and, and all the risk of the becoming homeless associated with mental illnesses.

We have had the opportunity to conduct a register-based studies of homelessness in Denmark, which is very rarely possible. But we have the register of people attending the shelter, and therefore we can follow them and see what - how many of them will have mental health contacts before they, they become homeless and also afterwards.

DWYER: Professor, I will return to that issue of what Denmark has done when we come to look at some recommendations in Australia. But before I leave you for the moment, you were president of the Danish Psychiatric Society from 2021 to 2025. As president of the Danish Psychiatric Society, you were an advisor for the National Health Agency, is that right?

WITNESS NORDENTOFT: Yes. We were a large group of people invited for the Danish Health Agency to give advice regarding a ten-year plan for psychiatry, so I played a role in that, and it has just been launched and decided.

DWYER: That is the ten-year plan for psychiatry for Denmark has just been launched and decided?

WITNESS NORDENTOFT: Yes, it was just earlier this week. It was - the parliament decided how to fund the ten-year plan for psychiatry, and there is in it a psychiatric team for homeless people.

DWYER: Included within that role was you being appointed to a Ministry of

Health taskforce investigating the conditions that led to a mass casualty in Copenhagen, Denmark, in July 2022 when a young man in a severe psychotic state killed four people and wounded many others in a mass shooting incident in a shopping mall. Could you please tell her Honour, firstly, what was the nature of that investigation and what were the key conclusions?

WITNESS NORDENTOFT: It was an investigation initiated by the Minister for Health who wanted the society to learn as much as possible from this very sad event where four people died and many people were wounded. And they wanted to learn as much as possible, and therefore this taskforce was formed.

DWYER: Was there a report that flowed from that taskforce?

WITNESS NORDENTOFT: Yes, there was a report and some recommendations.

DWYER: Did the report note that there were - or find that there were any missed opportunities to help the young man who had committed those terrible acts?

WITNESS NORDENTOFT: Yes. There were several missed opportunities. One was about diagnosis. It has between the psychiatrists been discussed whether this man had schizophrenia or autism, and it ended up with a recommendation on more thorough training of psychiatrists in psychopathology. So, to be aware of subtle symptoms, or hidden symptoms I would indeed say, because they were not that subtle, but they were, they were not really hidden. So that was one recommendation.

Another recommendation was more continuity of care, because for this man, he had actually had contact with mental health services, but he had seen many different people. And even though it was evident that he has had thoughts about attacking and killing someone, he didn't reveal it. Or he at some moment he tried to reveal it, but he spoke to 14 different people for the last six months before he finally did this attack, and one conclusion was that if we should hope that somebody should confide and tell about very scary impulses, it would be needed to build trust so that the person would feel safe in trying to reveal violent impulses.

DWYER: So am I right that ultimately it was determined that that young man had experienced schizophrenia rather than autism?

WITNESS NORDENTOFT: Yes.

DWYER: And that--

WITNESS NORDENTOFT: And, and that--

DWYER: Sorry, please go on. Sorry.

WITNESS NORDENTOFT: Yeah, and I think that has been confirmed. Yeah,

during the, during the trial and when he was, he was also observed for whether he was suited to have an ordinary punishment in prison or whether he should be treated as a forensic patient. And he is now treated as a forensic patient, being given treatment for severe schizophrenia.

DWYER: I will return to that study potentially when we look at the issues of masking some symptoms and the ability of patients to do that on occasion and the issue of continuity of care.

Dr Heffernan, I should ask you to please state you full name for the Court?

WITNESS HEFFERNAN: Yes, my full name is Edward Bonaventura Heffernan.

DWYER: Where are you currently working?

WITNESS HEFFERNAN: I'm currently working in Brisbane Queensland as the Director of the Forensic Mental Health Service.

DWYER: You've prepared an expert report, again at the request of the Crown Solicitor's Office, for the assistance of her Honour. Your report sets out your background, as do your colleagues', but what is involved in being the Director of the Queensland Forensic Mental Health Service?

WITNESS HEFFERNAN: I have clinical responsibilities. So usually clinical leadership, direct clinical care of people who have usually severe mental illness and have been involved in contact with the criminal justice system in one way or another. I also provide supervision and mentoring to other psychiatrists, and also have a clinical governance responsibility. So, cases get escalated to me for advice about the treatment, management and ongoing care of individuals with mental illness who have contact with the criminal justice system.

DWYER: To summarise some of your experience, you've had two decades working with people with a mental illness, or over that time, and people who encounter the criminal justice system as a result of committing violent offences while they're suffering from serious mental illnesses?

WITNESS HEFFERNAN: Yes, so I've worked consistently in, in prisons, sometimes in courts, sometimes in high secure units, sometimes in the community with, with people who are at risk, look like they're at risk of offending or have offended and are on an order for that offending.

DWYER: You have been involved in incident analysis reviews, coronial matters and investigations of tragic, often very violent matters involving people with mental illness in a number of different Australian jurisdictions over the years as part of your work?

WITNESS HEFFERNAN: Yes, that's correct.

DWYER: You have co-led the establishment of the police and mental health services in Queensland over the past decade, and we'll come to that when we look at the interaction that Queensland Police have with Mr Cauchi. You're currently the clinical lead of the Queensland Police Communication Centre Mental Health Liaison Service that we've already heard much about. How did you come to be the co-lead for the establishment of the police and mental health services in Queensland?

WITNESS HEFFERNAN: Well, in around 2014 there was a number of significant tragic events that highlighted the need for enhanced communication between mental health services and police. And one of the ideas that had been proposed was to actually place clinicians inside the police and ambulance triple-0 call centres to assist in real time exchange of information, governed and protected by memorandums of understanding to protect the confidentiality of individuals, to help assist the outcomes for those individuals. And to also help enhance the police knowledge, when they were attending - or the ambulance knowledge, when they were attending to that first response. And also to help communicate what was happening in the community with the health system.

DWYER: Is there a continual review of whether or not Queensland Police are getting the best possible assistance in their dealings with mental health patients or people in the community?

WITNESS HEFFERNAN: Well, I, I can talk about the reviews of the Police Communications Mental Health Liaison Service. So there was an evaluation done of that service and it was positively evaluated. And out of that, it has been recurrently funded. Then there has been several studies looking at the prevalence of mental health calls, the challenges that people face before the call, what happens in the incident, what happens after the incident, and all that data and information has led to the Queensland Government, through the Better Care Together funding, to expand the service which is currently in process now.

DWYER: Do you still have a role in reviewing those processes?

WITNESS HEFFERNAN: Yes, most days.

DWYER: Before I move on I just want to note this, that you're a member of the Queensland Mental Health Review Tribunal, Deputy Chair of the Psychiatric Medical Assessment Tribunal, and a Professor in the Faculty of Medicine at the University of Queensland?

WITNESS HEFFERNAN: Yes, that's correct.

DWYER: And are the qualifications set out in your report.
Professor Anthony Harris, seated to your right, you've also prepared an expert report at the request of the Crown Solicitor's Office. You're a Professor of Psychiatry and the Head of Speciality of Psychiatry at the University of Sydney, is that right?

WITNESS HARRIS: That's correct.

DWYER: You've been practising for over three decades?

WITNESS HARRIS: Yes.

DWYER: And your area of practice includes community youth mental health, and a particular area of research interest is schizophrenia and the associated psychosis, is that right?

WITNESS HARRIS: Correct.

DWYER: You're a senior staff specialist in the Prevention Early Intervention and Recovery Service. What is that service?

WITNESS HARRIS: That is a youth mental health service that is part of the Western Sydney Local Health District. It provides youth mental health services to people with a moderate to severe illness, aged between 12 and 25. I care for people who are in the more adult part of that, of that age spectrum. The service covers the Hills, Parramatta, Merrylands and Auburn areas, about - with a population base of about 550,000 people.

DWYER: You have both a clinical and a research interest, as do your colleagues, is that right?

WITNESS HARRIS: Yes and a, and a teaching role as well, of course.

DWYER: With respect to the area of schizophrenia and associated psychosis, can you tell her Honour about some of your work there?

WITNESS HARRIS: Yes. So I have been involved in a series of pieces of research that cover areas of neuroimaging, of treatment with new - with medication in pharmacological trials, of treatments, particularly with a psychosocial treatment called cognitive remediation therapy, aimed at improving the cognitive symptoms of people with schizophrenia, and with - that's the primary part of that research, with people with schizophrenia.

DWYER: I won't be able to do justice to any of the qualifications of our panel, but finally, you're also a Director of Mind Australia. That's a leading non-government organisation specialising in the care of seriously mentally ill people in the community, including their housing, have I got that right?

WITNESS HARRIS: Yes, I am.

DWYER: How long have you been a director of that not for profit organisation?

WITNESS HARRIS: I've been a director of Mind since January of last year, January 2024. However, the - I am there as I was a member of the Schizophrenia Fellowship of New South Wales for approximately 20, 25 years,

and that organisation merged with Mind to form a larger national organisation in, in January of, of 2024.

DWYER: What are the objectives of the organisation?

WITNESS HARRIS: Quite simply, the, the objectives are to, to make the lives of people with a severe mental illness better, as they're stigmatised, and the services that are provided within this country nationally are, are not up to the task.

DWYER: Are there different standards of services available throughout Australia for people who suffer from a severe form of schizophrenia?

WITNESS HARRIS: Yes, and, and that's one of the, the difficulties. The, the services are, are very varied, they're inequitably distributed, the system is - well, there is very little in the way of a true system for, for care and they are - the services available are sometimes only available according to your financial means.

DWYER: Does that organisation, Mind Australia, aim ultimately to try and standardise those services and provide a higher standard of care?

WITNESS HARRIS: Yes, that's, that's the aim of the services - the aim of the organisation is to, is to improve the, the level of services and to, to provide them in as many places as we can.

DWYER: I might come back to you when we look at the services available to Joel Cauchi in Toowoomba versus Brisbane, and then what might have been available to him in New South Wales when we look across that spectrum. But before I do, one of the series of questions I'll ask the panel about is about guidelines in relation to the treatment of severe forms of schizophrenia, and particularly those persons on clozapine. Are there different guidelines applicable in the different States and Territories of Australia?

WITNESS HARRIS: Each State has some guidelines in regard to certain specific areas, such as the initiation of clozapine or, or maintenance. Those guidelines tend to be quite similar. However, overall, the guideline that I think we should be referring to is that written - published and held by the Royal Australian and New Zealand College of Psychiatrists in 2016.

DWYER: We will come to that guideline, but before I come off it, is it the case that that guideline is in a state of review currently?

WITNESS HARRIS: That's correct.

DWYER: Perhaps an apt time for this panel of five experts to offer their opinions on it. Professor Olav Nielssen, you have also prepared an expert report at the request of the Crown Solicitor's Office on behalf of her Honour, so the fourth report prepared at her Honour's request. You are a psychiatrist at St Vincent's Hospital, and a Professor of Psychiatry at Macquarie University.

Can you tell her Honour how long you've been practising for?

WITNESS NIELSSEN: Since 1993, so 32 years. Anthony and I studied together.

DWYER: I see. You have, as your other panel members, a research interest and also a clinical interest. I want to come to both of those before I come to your public advocacy on housing for people with a mental illness. In terms of your clinical work, could you outline it, both currently and prior?

WITNESS NIELSSEN: Yes. I mean, I've got an old guy's private practice with, you know, a cohort of long suffering patients. I've, I've been doing a clinic at the Matthew Talbot Hostel, which is a sort of walk-up service for people who have experienced homelessness or risk of homelessness or are sleeping in the open - as is often the case - for the last 18 years, and about half of the people who come to that clinic - not half the people are homeless, but half the people that come to that clinic have a persistent psychotic illness.

Before that I, I worked for about 15 years in prisons, which are kind of like our new asylums, and coming to the Matthew Talbot, it was just an extension of the criminal justice system. A large proportion of the people I've seen there rotate in and out of prison. I did ten years on the Mental Health Review Tribunal, reviewing - on the forensic side of it, reviewing release orders for forensic patients. And they're typically tragedies that might have been prevented.

DWYER: Yes.

WITNESS NIELSSEN: The, the - there's been quite, quite a - I'm a consultant at MindSpot Clinic, which is at Macquarie University, which treats anxiety and depression online, and I have a teaching role there as well and have students come to the homeless sector.

DWYER: The private clinic you refer to is the Level 8 Practice, is that right?

WITNESS NIELSSEN: Yes.

DWYER: You see private patients at that clinic?

WITNESS NIELSSEN: Yes.

DWYER: Then you see public patients through your work at the Matthew Talbot Hostel?

WITNESS NIELSSEN: Yes.

DWYER: The Matthew Talbot Hostel, am I right, provides both an accommodation service - is it a short-term accommodation service?

WITNESS NIELSSEN: Well, it's ostensibly three months, but they're pretty

liberal with it, but it has shrunk terribly. And all the hostels have shrunk. So the, the availability of hostel accommodation has been greatly reduced, including since COVID.

DWYER: We'll come to this when we talk about the availability but just since you raised it, I think you say in your report some statistics about the - there used to be 1,300 beds, there's now, in the course of - in the number of about 300. Can you remind us of the exact statistics and the way that's changed over the decades?

WITNESS NIELSSEN: Yes, well, in - when I was training at St Vincent's, one of our - our service provided outreach services to the four big hostels. Matthew Talbot was the biggest, which had 450 residents. Now it's got 66. So - and the, the decline from 1,100 I estimated to less than 300, it exactly coincides with the number of people who sleep in the open in, in Sydney every night - in the inner city Sydney every night. So that's - I don't know if that's - that's probably more than a coincidence.

HER HONOUR: Just to be clear, that's the number of beds available has reduced, not the number of people going to those--

WITNESS NIELSSEN: That's right, yeah, the - there's now 300 hostel beds, whereas there was once at least 1,100 and, and our census shows that about 750 people sleep in the open in the CBD.

HER HONOUR: Thank you.

DWYER: What is the reason for that reduction in beds?

WITNESS NIELSSEN: Occupational health and safety, a preference of, of the staff, the, the funders. The funding is partly philanthropic, but it's also partly from Communities and Justice, and they considered the, the dormitory beds to be of too low a standard, even though it's - you know, it's shelter.

DWYER: So where the Matthew Talbot beds have been reduced, no equivalent service has picked up those persons?

WITNESS NIELSSEN: Not that I know of. Not to those numbers, that's for sure.

DWYER: We'll return to that issue, but is that partly the driver for you founding Habilis Housing?

WITNESS NIELSSEN: Well, yes. I mean, the driver really - I suppose I've seen the model operating, because I did sort of provide a clinic at a boarding house early in my career, which was very successful. No-one was readmitted to hospital if they were treated. But I have conducted some research with the - it's now about 3,500 individual people I have on a database through our homeless service and, and what was alarming about that research was the number of people who had lost public housing accommodation which, you

know, should be like owning a house, really, to have that kind of a lease.

And, and it's because they just lack the, the skills without the supports, and they were very predatory, some of these public housing estates. So the model is small clusters of supported housing - it's actually very like the housing provided by the organisation that, that Professor Harris is part of, which is the Haven Foundation in Victoria, which is merged with Mind and I'm hoping to replicate a similar model in New South Wales. And in fact it is exactly the model that was envisaged by the Richmond Report of 1982, but we had other priorities.

DWYER: Just to flag, before I move onto Professor Large as our final panellist, I will come back to this issue of the deinstitutionalisation in Australia and the Richmond Report, what the aim was at the time in terms of community housing, what has become a shortage in the aims not being fulfilled, and your work, Professor Nielssen, at Habilis, and your work, Professor Harris, at Haven. I note before we leave you, Professor Nielssen, that you're a member of the College of Psychiatrists Committee that was engaged to develop the guidelines for the treatment of schizophrenia. Are they the guidelines that Professor Harris referred to earlier that are now dated 2016?

WITNESS NIELSSEN: Yes, yes. They're - yes, that's, that's, that's the one. They're really out of date, I suppose. But they're - not that there's been that much new, in fact. But, but my contribution to that or the reason that I was drawn onto that committee was in forensic topics but also homelessness and, and treatment of chronic psychosis.

DWYER: We will return to that. Professor Large, you've prepared two reports. They were prepared at the request of the legal team that appears for Dr Boros-Lavack, is that right?

WITNESS LARGE: That's correct.

DWYER: Professor Large, I'll come to your qualifications very shortly, but there was just one correction that I think you wanted to make with respect to your second report, is that right?

WITNESS LARGE: On Tuesday night when I was reviewing my materials, I noticed that my point 92 in my second report has a typographic error, and it relates to Mr Cauchi's first application for a firearm licence. And at point 92 I say that it was November 2012, but it's actually 12 November 2001. It's actually also - that's the correct - that's, that's at point - on page 1951. It's simply a typographic error on my part. And in my formulating my opinion, I did know that that first application was in 2001 and not in 2012.

DWYER: I see. Would you mind - do you have your report in front of you, Professor?

WITNESS LARGE: I do, yeah.

DWYER: Could you just read to us the whole of the sentence as it should read now with that correction?

WITNESS LARGE: Sure. If you just give me two seconds.

DWYER: Please.

WITNESS LARGE: I apologise for this. I--

DWYER: Not at all.

WITNESS LARGE: My latent dyslexia has got the better of me. So point 92 should read:

> "The medical record includes a letter from the Weapons and Licencing Branch of the Queensland Police stating that Mr Cauchi's application was awaiting determination and that more information was needed about the injury or illness after an application by Mr Cauchi to the Queensland Police in November 2012", but it should be November 2001.

DWYER: Just to make clear, we know that Mr Cauchi made an application for that licence in 2001 and made a further application in 2021. Unsurprisingly, we will return to that issue.

WITNESS LARGE: And the final sentence was, "There is no evidence in the file that the health service provided information to the police". I couldn't find any.

DWYER: Thank you very much, Professor Large. Just returning to your qualifications. You're a Senior Staff Specialist psychiatrist and the Medical Superintendent of Mental Health Services at the Prince of Wales Hospital in Sydney?

WITNESS LARGE: That's correct.

DWYER: You, like your colleagues, have both a clinical and research interest, and also an advocacy interest which I'll return to, but could you please tell her Honour how long you've been practicing and your areas of interest?

WITNESS LARGE: I've been a psychiatrist since 1995. I've got a very broad range of interests. So clinically I'm pretty - I have worked in private practice a little bit at the beginning of my career but I'm very much a public psychiatrist. I've alternated between working in inpatient wards.

DWYER: Sorry, Professor, could you keep your voice or move--

WITNESS LARGE: Sorry.

DWYER: Thank you very much.

WITNESS LARGE: I've alternated between working in inpatient wards and emergency departments. You can't work in emergency departments for more than a couple of years without needing a bit of a break. And I've done community and acute care community work as well. My clinical interest really is in schizophrenia and, and psychosis because that is the core of public psychiatry, and the reason I left private practice partly was because I found it so difficult to look after the disorders I was most interested in.

My research has been quite broad and interests have been quite broad and have been shared with a couple of people on the panel here. My primary interest has been suicide. There was a period when I published a large number of papers about homicide with Dr Nielssen. I've--

DWYER: I'm so sorry, Professor, can I just stop you. With the rain that's coming down on the roof, it's more difficult to hear you, so--

WITNESS LARGE: I'll try to be loud. Sorry. I, I feel like I'm speaking loudly but everyone else tells me I'm quiet. I've had a - I've got an ongoing interest in cannabis and psychosis and was the chief investigator in a very influential study that showed that cannabis use brings forward the age of onset of psychosis in 2011. And I've got an ongoing but low - I am continuing to do cannabis research.

And I've also got an interest in clozapine and was a co-author and did the statistics for two articles that have proven to be quite influential in the dropping of the requirement for blood monitoring for clozapine in the United States, a reform that hasn't actually happened here.

DWYER: Are you able to provide those articles? Are they attached to your--

WITNESS LARGE: They're not attached but I could easily provide them there.

DWYER: Thank you very much. We'll return to that issue when we come back to the guidelines. You are a conjoint professor in the discipline of Psychiatry and Mental Health at the University of New South Wales, is that right?

WITNESS LARGE: I am, but I'm employed by the hospital.

DWYER: Professor Large, I referred to your advocacy work, and in fact you and Professor Nielssen have researched and written together about risk assessment and suicide, is that right?

WITNESS LARGE: Extensively.

DWYER: One article that was published by both of you appeared in the Sydney Morning Herald shortly after the tragedy unfolded at Bondi Junction on 13 April last year. It was an opinion piece, "Schizophrenia and homelessness can be a deadly combination". You share Professor Nielssen's concern about

the exacerbation of mental health issues, particularly schizophrenia and psychosis, by homelessness?

WITNESS LARGE: Yes.

EXHIBIT #6 ARTICLE ENTITLED "SCHIZOPHRENIA AND HOMELESSNESS CAN BE A DEADLY COMBINATION" TENDERED, ADMITTED WITHOUT OBJECTION

DWYER: I've got copies if anybody would like to read it over the break. I should say that the sub-headline, or the byline is - sorry, the byline is that it's written by both of you and the title is, "Schizophrenia and homeless can be a deadly combination. Homicide of strangers by people with schizophrenia is extremely rare, but we can reduce the risk by fixing our homelessness crisis". That's something that you feel passionate about. Is that fair to say, Dr Large?

WITNESS LARGE: There are lots of things I'm extremely interested in and it's a very fascinating area to be working in. And homelessness is a terrible problem for people with schizophrenia. I, I, I think it's not inconceivable that homelessness can cause schizophrenia actually or can be a contributory factor. I, I, I can't see why that wouldn't be the case for some people. It's, I think, extremely stressful being homeless, and we know that psychosocial stressors of all sorts bring on - help bring on symptoms. It wouldn't be the sole cause ever. There'd have to be a lot of other things. But more importantly, it's really almost impossible to have treatment for schizophrenia if you're homeless.

DWYER: Does that underscore the need for services like Haven and Habilis that can provide a treatment model within the accommodation service?

WITNESS LARGE: Yes.

DWYER: Before we move on to the particular circumstances of Joel Cauchi, I'm going to ask some general questions about schizophrenia and the way it can present, the need not to stigmatise all people with schizophrenia, but the risk that the severe forms of the illness present. I don't imagine that there's a lot of controversy so I may not go to all of the panel in relation to this, but can I start with Dr Heffernan. Set out in your report at paragraph 2.4, page 4, you note of course that schizophrenia is defined in the DSM-IV, the--

WITNESS HEFFERNAN: Yes.

DWYER: --ultimate textbook for psychiatrists, as characterised by five key features: delusions, hallucinations, disorganised thinking, grossly disorganised or abnormal motor behaviour. What's meant by motor behaviour?

WITNESS HEFFERNAN: So physical, physical behaviour, physical movements.

DWYER: Which might include, for example, is it tics or agitation or odd

presentation of your body?

WITNESS HEFFERNAN: That, that can be, yes.

DWYER: Then the fifth one is negative symptoms that are predominantly a feature of schizophrenia. We have heard a discussion about positive symptoms, negative symptoms and cognitive symptoms of schizophrenia. Doctor, I think those are well understood but might you give just a broad outline of what you can expect from positive, negative and cognitive symptoms?

WITNESS HEFFERNAN: Yes. So positive symptoms are probably the, the symptom spectrum that most people are familiar with when, when it comes to schizophrenia, and they're things like hallucinations, delusions, disorganised thoughts and the disorganised behaviour that's manifest from those three entities. So that's the positive symptoms.

The negative symptoms are really - and, and the neurocognitive deficits are really the things that contribute to the psychosocial adversity that's associated with schizophrenia. So the negative symptoms include lack of motivation, a reduced ability to express emotion, reduced thought production and a, you know, poverty of speech. And also a reduced ability to experience pleasure in activities. So that's the negative symptoms.

And the neurocognitive deficits are really a spectrum of deficits and they relate to things like verbal processing speed, again thought processing, and they also relate to things that we do with our frontal lobes like sequencing, organisation, abstraction and planning. And these of course are really important things in our day-to-day life.

And so when we think about schizophrenia it - often people focus on the positive symptoms of schizophrenia, but often the things that cause a really significant psychosocial disability are the negative symptoms and the neurocognitive deficits.

DWYER: We know that there are different severity levels of schizophrenia, but in treating somebody who comes to you with a diagnosis, are you aiming to address each of those three areas? That is to eliminate positive, negative and cognitive symptoms if possible?

WITNESS HEFFERNAN: Yes, that's right. It is - "elimination" is perhaps a strong word. I think really what, what, what we're focusing to do is target all those areas. So, positive symptoms are often treated well with psychological treatments but also medication treatments. And the neurocognitive deficits are often treated well with certain therapies and there might even be medication that can assist there. And, you know, the negative symptoms are, are treated with largely psychosocial interventions, but there is a limited amount of evidence that some medication such as aripiprazole might enhance the negative symptoms.

So the idea is really to have a multidisciplinary team involved in the treatment of schizophrenia so you can target the biological, psychological and social components that those three deficits combined cause.

DWYER: Professor Nordentoft, you were listening to all this. I take it you can hear your colleagues?

WITNESS NORDENTOFT: Yes, I can.

DWYER: You've just heard Dr Heffernan outline the treatment aims and the modalities that are available. Is that the same in Denmark?

WITNESS NORDENTOFT: Yes, it is. I, I think there's agreement all over the world that medication can play a role especially for psychotic symptoms, hallucinations and delusions, and that therefore - there might be some limited effect also on negative and cognitive symptoms, but psychosocial intervention would be the key issues for those issues. For cognitive remediation could play a role for the cognitive symptoms. And for negative symptoms it would be something like social skills training and comprehensive care.

DWYER: Professor Nordentoft, I'm going to come back to you in one question, so if you could just hold for one moment. What you also go on to say, Dr Heffernan, just to be clear, at paragraph 2.5 - I'm just going to summarise this so we can move on from the general - certain criteria must be met for a diagnosis of schizophrenia to be made. First, two or more of the five features that I read out of a psychotic disorder must be present for a significant proportion of time during a one-month period. Second, there must be a decline in function such that from the onset of those features the person experiences a disturbance in their social, occupational or self-care functioning that is demonstrably poorer after the onset of symptoms.

Third is the duration of the condition. There must be evidence of the first two criteria being present for at least six months. Fourth relates to the exclusion of other relevant mental disorders, and the fifth criteria relates to the exclusion of substances or a general medical condition being relevant causes. I'll pause there. So you would have to ensure, for example, that somebody who is exhibiting very strange behaviour and appears to have motor disturbances does not in fact have another diagnosis like an autism spectrum disorder or something else, is that right?

WITNESS HEFFERNAN: Yes, that's correct. So, psychosis, for example, is a final common pathway of a number of things that can affect the brain, one of which is schizophrenia.

DWYER: The onset of schizophrenia can include a prodromal period whereby some of the symptoms become evident but manifest in a less pervasive or attenuated nature. By "some of the symptoms", could that include agitation, anger, confusion?

WITNESS HEFFERNAN: Yes, and, and commonly also includes things like a

change in motivation, a change in apparent interpersonal interaction, and, you know, a change in the level of function.

DWYER: Your last sentence of this paragraph is that "Schizophrenia is a severe psychiatric disorder that is usually chronic, has a relapsing remitting course and may lead to persistent symptoms throughout adult life." Are there varying degrees of schizophrenia? That is, can people have a mild form of that disease?

WITNESS HEFFERNAN: There are. Schizophrenia is a spectrum, and that spectrum is characterised by people who have a first episode of schizophrenia and can recover and actually have full recovery. Then there are people who have recurrent episodes of exacerbation of schizophrenia, but inter-episode recovery. Then there are people who have recurrent episodes of schizophrenia and poor inter-episode recovery. And then there are people who have just persistent stigmata of schizophrenia.

DWYER: Professor Nordentoft, does this tie into what you say at paragraph 38 which is this:

> "At least one-third of people with schizophrenia experience complete remission of symptoms. Some people with schizophrenia experience worsening and remission of symptoms periodically throughout their lives, others a gradual worsening of symptoms over time"?

WITNESS NORDENTOFT: Yeah.

DWYER: It's a spectrum. Are there any--

WITNESS NORDENTOFT: Yes, I--

DWYER: You say at least one-third experience complete remission of symptoms. In those circumstances, would there be a need for follow-up?

WITNESS NORDENTOFT: Yes. But, I, I think there will be many cases where it's not happening. There's one-third who achieve remission of psychotic symptoms. Actually, in some cases it's even more. Some of them are still being treated with antipsychotic medication and that's the reason for the remission. But we also see cases where it's possible to taper out antipsychotic medication, and who do not receive - and who do not have a relapse of psychotic symptoms. But that's a, that's a group. It has been described also in recent papers. It is around 20%.

DWYER: Dr Heffernan, before I move on to the others, I just want to address this issue of statistics and then give the panel an opportunity to comment. At paragraph 2.2 when you're explaining to us what schizophrenia is, that it's a brain disorder associated with those symptoms, you say this:

> "The most comprehensive study in Australia estimated the 12 month treated prevalence in the public mental health services of people

> with psychosis was 4.5 people per 1,000 population. Over 90% of individuals with a psychotic disorder will have multiple episodes, relapses, or a chronic condition, and the impact of their inter-episode function varies significantly from mild to severe."

Does it follow that once there is a psychotic element of schizophrenia, there is a much greater risk of relapse?

WITNESS HEFFERNAN: Firstly I'll just explain that study. So, that's the survey of high impact psychosis. So, that's the biggest study that has been done in Australia. What it doesn't reflect, of course, is people that are homeless or out of treatment. So, just, just to make that point, because these are people that are in treatment, a survey of people in treatment. And then could, could I just go back to your question? Would you mind restating it?

DWYER: Please. You offer this statistic:

> "Over 90% of individuals with a psychotic disorder will have multiple episodes, relapses, or a chronic condition, and the impact of their inter-episode function varies significantly from mild to severe."

WITNESS HEFFERNAN: Yes, that - that's restating what I, what I said earlier, and that was the findings in the, in the SHIP study, meaning that it's a, it's a smaller percentage of people that will have a full recovery and not have symptoms of schizophrenia--

DWYER: I see. Your last sentence there is that "Schizophrenia usually requires lifelong care and treatment, including the use of antipsychotic medication". Are you referring there to all forms of schizophrenia?

WITNESS HEFFERNAN: I'm, I'm, I'm using the word "usually" very deliberately, because there can be times when people have a full recovery and don't need ongoing treatment. But in the majority of circumstances, as was evident through the, the SHIP study, people will have a spectrum of ongoing symptoms for the rest of their life, from mild to severe. And I would argue that all of those forms on that spectrum require a varying amount of input from mental health services, and a varying amount of mental health care.

DWYER: Professor Large, is there anything that you wanted to add or change on that?

WITNESS LARGE: A couple of things actually. So, schizophrenia can't be diagnosed without the presence of psychosis. So, you have to, you have to have had psychotic symptoms to be diagnosed with schizophrenia.

DWYER: I see.

WITNESS LARGE: And schizophrenia does exist on a spectrum, but it is itself a serious disorder. So, people with mild schizophrenia may still be quite disabled. So, there's a - you know, something that might be mild within the

spectrum of schizophrenia might be a very significant problem. And in fact, the threshold for diagnosis of schizophrenia is quite high. You have to be - have on - you have to be disabled by it.

So, with respect to the SHIP study, about 50% of people with schizophrenia were treated by - primarily by their general practitioners and not by specialist mental health services. The point prevalence of schizophrenia internationally is thought to be about - it varies a bit, but it's thought to be about 6 per 1,000 or .6 per - .6%. There are 28 million Australians, so that would imply that there were about 165,000 people with schizophrenia.

Now, I can't find a study that looks at adherence to schizophrenia that shows that more than 70 or 75% of people are adherent. So, you know, people don't take their antihypertensives, they don't take their antidiabetic medication. They don't even always adhere to cancer medication. And schizophrenia is not that different, and by that measure, there are probably today around 50,000 people in Australia with schizophrenia who are not currently receiving antipsychotic treatment. They may be having other treatments, but they're not currently receiving antipsychotic treatments.

DWYER: I'll come to the severe form shortly, but Dr Nielssen, is there anything that you wanted to add to that?

WITNESS NIELSSEN: No, well I agree pretty much with the numbers from Dr Large - Professor Large. And, and I see plenty of untreated people with schizophrenia in the homeless sector coming to the clinic and refusing to have treatment, but not really being good candidates for involuntary care. And, and I also agree with the comment earlier that it's very hard to provide ongoing care for someone who doesn't have a place to live.

DWYER: I'm just again staying with the general rather than Joel's diagnosis about which there might be some conjecture. But all of the panel refer to a condition known as treatment-resistant schizophrenia. Dr Heffernan, again, you describe that as:

> "commonly defined as a failure to respond to two or more antipsychotic medications given in an adequate dose for at least six to eight weeks. clozapine is the medication indicated for treatment-resistant schizophrenia. It's generally considered, along with other aspects of treatment, care and monitoring, that this should be lifelong medication, and that if it is ceased, the risk of relapse and readmission are significantly increased. Both the Royal Australian and New Zealand College guidelines and the American psychiatric guidelines for the management of schizophrenia recommend that patients with treatment-resistant schizophrenia be treated with clozapine."

Dr Nielssen, do you agree with those opinions?

WITNESS NIELSSEN: Definitely, yes. It's - well, firstly, I - I'd say

schizophrenia - all, all schizophrenia is treatment-resistant, really. If you fully recover in all respects, including functional recovery after having had a - an episode of psychosis, defined by having had a delusional belief, then it's not schizophrenia. Schizophrenia has residual impairment. But, however, the - it's the more severe impairment and the, and the presence of continuing active symptoms that, that lead you to say it's a treatment-resistant form of schizophrenia. But, but, yeah clozapine is the best we have.

DWYER: Do you agree with what is set out by Dr Heffernan, that it's generally considered that clozapine should be a lifelong medication, and if it's ceased, the risk of relapse and readmission are significantly increased when you're dealing with treatment-resistant schizophrenia?

WITNESS NIELSSEN: Well, most definitely. Because especially in Australia where there's a little bit of a bureaucratic threshold to, to initiating clozapine. So, we have really reserved it for people with more severe forms. Those, those patients are the ones with the, the greatest chance of relapse. And also have, in the course of forensic practice, come across quite a few very severe and catastrophic relapses of people who'd previously been on clozapine, putting aside this case.

DWYER: I'll come straight back to that actually, Dr Nielssen, but I'll just go to your colleagues. Dr Harris, do you agree with that outline by Dr Heffernan?

WITNESS HARRIS: Yes, I do.

DWYER: Professor Nordentoft, do you agree? Is that the situation in Denmark? I'll start with the definition of treatment-resistant schizophrenia, the failure to respond to two or more antipsychotic medications given in adequate dose for six to eight weeks?

WITNESS NORDENTOFT: Yeah, I do - I would agree in that definition, and, and within the panel, we have had some discussions whether we could consider Joel Cauchi's case as treatment-resistant or chronic. Because he actually, after eight or ten years, responded. So in that way, you could say it was not completely treatment-resistant, because he was able to respond on, on medication. And so, in, in that way it is a chronic condition, but he was actually responding to clozapine.

DWYER: I might just pause that. I'm going to outline for the panel different symptoms that Joel experienced - positive, negative, and cognitive - throughout his time in the public sector up until 2020 and thereafter. If I might just put a pin drop in that and come back to you, Professor Nordentoft, about it.

Can I just ask you about the general statements in relation to the treatment for TRS, or treatment-resistant schizophrenia. Dr Heffernan said:

> "It's generally considered, along with other aspects of treatment, care and monitoring, that clozapine should be a lifelong medication for treatment-resistant schizophrenia, and if it's ceased, the risk of

relapse and readmission is significantly increased".

Is that the situation or opinion widely shared in Denmark?

WITNESS NORDENTOFT: Yes, generally it is shared, but it does not exclude to try to reduce the dose and, and it does not exclude that you, in some cases, because of side effects, could try to replace clozapine with something else, with some other, other kind of antipsychotic medication. But generally, clozapine is the, the, the drug of choice in severe cases where other forms of treatment does not work, and, and it is generally recommended to have it for a very long period.

DWYER: Professor Large, did you want to say anything about that? I accept that there is a different view in relation to Joel, and I'll come back to that. But generally?

WITNESS LARGE: So, a lot of patients do come off clozapine. Mostly they take themselves off. It is often associated with relapse. But clozapine causes myocarditis, hepatic problems, gastrointestinal problems, and haematological problems. So, it's actually not all that rare for patients to have to come off clozapine. There's also another group of patients who are, in a sense, although they're treatment-resistant, are too sick to be on clozapine, because you have to have - you have to be able to adhere to regular blood testing, and who won't take oral medication. So, our mostly - most severely unwell treatment-resistant patients are on - often on high dose intramuscular second weekly, monthly, up to now three monthly injection. So, our, our most severe and most treatment-resistant patients are actually not on clozapine.

DWYER: In circumstances where your most severe and most treatment-resistant patients are not on clozapine, are they on another form of antipsychotic medication?

WITNESS LARGE: They're on long-acting intramuscular antipsychotics that are not as effective as clozapine but do provide some sort of muting of the extremities of their illness, and provide, I think, quite modest protection. I mean there's a very high rate of comorbid substance abuse among patients with schizophrenia, estimated to be 60% in some studies. Mostly cannabis, but unfortunately also stimulants in Australia, and tobacco of course. And medication provides some modest protection against the use of illicit substances.

While talking with my patients about this I say that, you know, medication is like a Mini Moke and methylamphetamine is like a Mack truck. It's really - you have to be quite concrete in your explanations. So, our most severe patients are in and out of hospital on involuntary monthly injections of antipsychotic medication - they're too unwell to have clozapine - and use substances. And they're not a small cohort.

DWYER: Professor Large, do I take from, including in what you said, that the relevance of other antipsychotic medication is not just managing symptoms of

schizophrenia, but it might be that it prevents some of those patients going back onto illicit drugs?

WITNESS LARGE: I don't think that there's really - there's some evidence actually that clozapine does reduce use - the use of the illicit drugs. I don't think there's evidence that other antipsychotics reduce the use of illicit drugs, but they may blunt their effects somewhat.

DWYER: I just want to come to the risk of relapse, because Professor Harris, you deal with this in your report. Taking Joel as an example - and I'll return to the specifics - you say this at paragraph 4.2, "The decision to reduce Joel's clozapine dose from very high levels was appropriate". At paragraph 4.3:

> "Although I would have preferred for Mr Cauchi to remain on clozapine in a range of 300 to 400 milligrams a day augmented by a low dose of aripiprazole, Abilify, such as what he was on. The decision to trial cease of his medication was not unreasonable".

You go on to say:

> "Schizophrenia is highly likely to relapse in the absence of a maintenance dose of antipsychotic medication, and the best medication to select for the maintenance treatment is usually the one that has stabilised the person at the dose they are able to tolerate well".

And then you say:

> "Discontinuation of antipsychotic medication is accompanied by a very high relapse rate, estimated to be up to 77% in one year and 90% at two years, compared to a relapse rate of those people who were maintained on medication of less than 10%".

Can I suggest to you, are we right to read that statement, Dr Harris, as a strong piece of advocacy for maintaining a patient on an antipsychotic medication that they have been demonstrated to tolerate well, where they've experienced a severe form of the disease?

WITNESS HARRIS: Yes, it is. And it's something that I think most psychiatrists would strive to do. However, in the, in the situation where a patient has - is competent and, and wishes to discontinue medication because of the burden of adverse effects, then at times, it's best - it is best, in my view, to cooperate with the patient and manage a slow and, and staged withdrawal of the medication.

DWYER: In those circumstances, is it important to explain to the patient what the benefit and risk is of the disease? So, for example, some patients will experience severe side effects on clozapine or other antipsychotics, other persons will experience very mild side effects. If the risk of relapse is 90% within two years, in those circumstances, you'd be explaining that very

carefully to the patient, wouldn't you?

WITNESS HARRIS: Yes, very carefully, and--

DWYER: And to their family?

WITNESS HARRIS: And to their family. And to try and bring to them as an individual person what the balance of, of risk as against benefit of, of coming off medication. The risk of relapse and perhaps rehospitalisation, or loss of the progress that they've made thus far in their recovery, as against coming off the medication, not having to have continued blood tests, continued post-monitoring, and the release from the side effects - which are considerable - from clozapine.

DWYER: Dr Heffernan, do you want to add or address any of that evidence, or do you agree?

WITNESS HEFFERNAN: I'd agree with the evidence given.

DWYER: Dr Nielssen, are you in agreement with Dr Heffernan?

WITNESS NIELSSEN: Yes, and Dr Harris, yes.

DWYER: Professor Nordentoft, you've listened to three of our Australian psychiatrists so far. Are you in agreement with that position?

WITNESS NORDENTOFT: Yes, generally. But I would like to mention that in Denmark in the Copenhagen area, we have a deprescribing clinic where people who would like to try whether they can taper out of antipsychotic medication are offered closely supervised tapering of the medication. And some people are actually, even after many years, able to taper their medication off. But then they are followed for at least 18 months to see if there's any sign of relapse.

The majority cannot taper off, but what happens when you do that very carefully, and in collaboration with the patient, is that you - that they - the patients actually get a higher level of acceptance that this treatment is needed. So that, that can be a positive effect of, of this collaborative effort to try to see how low dose can you actually still - where can you still have control over the symptoms.

DWYER: What's meant by close monitoring in that context, or does it differ for each patient?

WITNESS NORDENTOFT: It means weekly. Yeah, it, it means weekly contacts. And, and I think we will maybe come back to that. I think it's important with continuity of care, because I think most people can actually in an interview state that, "I'm okay", and, and that's, that's not enough. You need to have a close collaboration and where you are able to assess symptoms and the patient has confidence in you so that symptoms can be

revealed; it will need to be a thorough assessment.

DWYER: Professor Large, I'll ask you to comment on Professor Nordentoft shortly, but Professor Harris was the original report I started with. At paragraph 4.4, "discontinuation of antipsychotic medication" he offers:

> "is accompanied by very high risk of relapse rate, estimated to be up to 77% at one year and 90% at two years compared to a risk rate of those persons who are maintained on medication of less than 10%".

Do you have any comment on that in a general sense?

WITNESS LARGE: Look, I agree with that. But what it does indicate is that - 77 on 90 is a little bit beyond my powers of, of computation on the witness stand; I could probably do it off the stand, but a very high proportion of the relapses occur in the first year. More than 80% of the - more like 90% of the relapses occur in the first year.

DWYER: Just before we have a morning tea break, I just want to finish with the general lessons about schizophrenia. Professor Nordentoft, you remind us about the importance of not stigmatising persons who suffer from schizophrenia, and no doubt your Australian colleagues feel the same way. You say in your report under the subheading, "key facts", that "stigma, discrimination and violation of human rights of people with schizophrenia are common", and you impress on us the importance of not stigmatising the vast majority of people living with the illness of schizophrenia who will never go on to harm anybody else, is that right?

WITNESS NORDENTOFT: Yes, that's definitely right. I've been also interviewed on television when we have these rare occasions where people with schizophrenia kill somebody. It does happen. In Denmark it happens approximately once a year. And all the time, I stress that it's a very small proportion who actually go on to do something as bad as, as killing somebody, and for the vast majority of patients with schizophrenia, they are not dangerous to others.

DWYER: No doubt when there is one of those horrific acts, it makes it very difficult for those living with schizophrenia, and their families sometimes, to feel the pain of that?

WITNESS NORDENTOFT: Yeah, so in those cases, we are trying to protect the majority who are not dangerous, but also stress that the mechanisms behind those who are dangerous to others is usually psychotic symptoms. So it is often delusions that you are being followed and somebody is trying to, to harm you and therefore you need to protect yourself. So that's a more common mechanisms behind dangerous behaviours of the people with schizophrenia.

DWYER: Accepting that, and the very significant importance of not

stigmatising the vast majority living with schizophrenia, can I deal before the break with the very small percentage of people who do go on to harm others, often catastrophically. You say this, Professor Nielssen, at paragraph 32:

> "Most people with schizophrenia will never commit an act of serious violence, but a disproportionate number of homicides are committed by people with psychotic illness, usually because of the effect of acute symptoms of mental illness. Most victims are family members and people known to the patient. The homicide of strangers by people with schizophrenia is a rare event, occurring about one in New South Wales every two years or so".

Professor Nordentoft just said one a year in Denmark. You referred earlier, Professor Nielssen, to your knowledge of a number of patients who experience psychosis who had come off the drug clozapine and had gone on to commit a homicide, is that right?

WITNESS NIELSSEN: Yes.

DWYER: Are you aware of the numbers, just that you know of, over the last decade or so?

WITNESS NIELSSEN: Well, just off the top of my head, three cases came to mind, which are, you know, notorious cases. One was in a hospital, a psychiatric hospital, of a person just readmitted. But I'm not sure if any of those were amongst the homicides of strangers. Actually one was, now I think about it, the one at, one at Manly.

But, but the, the study of, of the homicide of strangers that Professor Large and I did with colleagues in Finland, the Netherlands and Canada - and the reason we did a multinational study was there were just too few cases really to get a signal - but, but we were then able to, to approximately, or to estimate how frequent it was, and it was rare. But the feature of the, of that small group were that they were more likely to be homeless. And, and being homeless probably was, was the signal, it was indicated a loss of continuity of care and perhaps more severe or more prolonged illness.

DWYER: Again, we might, we'll return to that in the recommendations. But in relation to the group of the very small number of people who have a mental illness with an element of psychosis who go on to kill others, were those three persons, the perpetrators, persons who had been taken off clozapine?

WITNESS NIELSSEN: No, I think all three cases they had - they, they had decided themselves to stop, and stopped abruptly. And a feature of clozapine is it wears off very quickly because it has a low affinity for dopamine receptors. It's an unusual drug in that regard. It makes it in some ways more tolerable from a neurological point of view, but it also means that it wears off. And the fact that we rely on people to be adherent to oral medication does create a limitation of, of its use.

DWYER: Is clozapine capable of being delivered by depot medication?

WITNESS NIELSSEN: Yes, it is. There, there has been a preparation, but of course our blood monitoring would forbid it, because once you get a low, a low neutrophil count - which is one of the worries - you can't remove it from your body for the next month or so, and I think that's one reason we hadn't considered it. It might be an innovation that might come to the United States now that they've taken a different view of the risks, but, but the answer is no.

DWYER: You're looking to Professor Large there, because he's been involved in the FDA guidelines in America, so that is an issue we will return to. Dr Nielssen, you attach an article to your report which is entitled "Rates of homicide and homicide associated with severe mental illness in New South Wales between 1993 and 2016". It was written with a number of colleagues, including Professor Large, and the findings in that were that between 1993 and 2016, the number of homicides not associated with mental illness in New South Wales had declined, but the number of homicides associated with somebody suffering from mental illness had remained the same, is that right?

WITNESS NIELSSEN: That's correct. And it's - I mean, it's - the - they're too small a numbers really to say, well, it's due to our - to, to failures of our - or, you know, poor performance of our mental health system. But that's definitely the implication. When, when you look at a homicide rate that's gone from two per hundred thousand to .7, you know, one of the lowest in the world, and yet our - the proportion and number of homicides by people with schizophrenia has remained exactly the same, that does look like a problem.

DWYER: The finding of yourself and Professor Large in that report was that nearly all of those homicides - 88.7% of those found not guilty by reason of mental illness had schizophrenia-related psychosis?

WITNESS NIELSSEN: Yeah, it's probably even higher, I think. And, and then of course you're looking at some people with epilepsy or dementia and that's the other small group. But it's - the way our law is framed, it's people with schizophrenia.

DWYER: The conclusion that you both reached was that:

> "The fall in conviction for homicide rates in the last 24 years has not been matched by a reduction in not guilty mental illness homicide verdicts. More assertive treatment of emerging psychosis and comorbid substance use disorders and improved continuity of care of chronic psychosis might prevent some homicides."

WITNESS NIELSSEN: Definitely, yes.

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

HER HONOUR: Yes. We'll take the morning adjournment and come back

at 11.

SHORT ADJOURNMENT

HER HONOUR: Are we ready to go now?

DWYER: Yes, your Honour, we are. That recording is working again. Panel members, I'm going to ask you some questions about the presentation of Joel Cauchi's disease over three distinct phases. The first is when he was experiencing first episodes or when he was experiencing obvious psychotic symptoms in 2001 and his readmission in 2002; a second phase of his treatment in the public system during that period and up until 2012, when he was transferred to Dr Boros-Lavack; and then finally from 2012 until June 2019 - I should say a fourth phase, then, from June 2019 when Joel was removed from all antipsychotic medication.

Dr Nielssen, much of this is uncontroversial in terms of the history, but you set it out in your report. You note at paragraph 57 that there was a service intake call with respect to Joel on 20 July in which his father Andrew reported problems. Andrew Cauchi reported that Joel had moved churches because of Joel's belief that he's a prophet. Andrew described his own issues in his background and delusions that he had had, and a letter from July 2000 from a general practitioner noted problems with Mr Cauchi - that is Joel's aggression, withdrawal, verbal abuse and threats to kill his father. There were also some threats against his sister. These are all prior to the admission in January 2001. Are they appropriately described as prodromal symptoms, some of them?

WITNESS NIELSSEN: Well, firstly, the, the transfer of churches was Andrew Cauchi, the father--

DWYER: I beg your pardon.

WITNESS NIELSSEN: --who was - who I understand also has a form of psychotic illness. But the other, the other symptoms were - they sound like early psychosis rather than prodromal. But the prodrome is the interval between an observed morbid change and the emergence of distinct symptoms of psychosis. So there's often a decline in social function, some mood symptoms, irritability, perhaps, you know, attenuated paranoid ideas. But that's the prodrome, and those, those features you just described sounded like by the time he'd become psychotic.

DWYER: I see. So Joel started experiencing those prodromal symptoms from around the age of 14. Is there anything you can say about the typical onset of serious illness - of this serious form of schizophrenia?

WITNESS NIELSSEN: Yes, well, in many respects it sounded quite typical, with a decline in, in social function and a decline in, in performance from being a, a scholarship student to, to not doing as well at school and then the emergence of frank psychosis in the last year of school is not at all uncommon.

DWYER: Professor Nordentoft, I could see you nodding there. Is that common, in terms of your experiences in treating patients with this serious form of illness?

WITNESS NORDENTOFT: Yes, I, I think it - I agree that usually the first episode - before that, there can be a phase with prodromal symptoms, but the symptoms described by his father and, and also noted in the records would be clear signs of the first episode of psychosis. So I think there were many, many symptoms presented when he had his first hospital contact, so clearly - actually a clear evidence that he was by that time suffering from schizophrenia.

DWYER: Does the panel generally agree with that? Is there anything anybody wants to add? I can see you nodding, Professor Harris and Professor Heffernan. Professor Large?

WITNESS LARGE: Yes, I agree with that, but the - globally the average duration of time between the onset of psychotic symptoms that could result in a diagnosis and the actual diagnosis and treatment, that period is known as the duration of untreated psychosis and it's remarkably long, of the order of a year in developed counties. Actually in some countries, some developed countries, even longer than that. And also in poor countries. But globally, it's around a year.

DWYER: What do you mean by that; that you have to experience those symptoms for that period of time before you're diagnosed?

WITNESS LARGE: No. That there are all sorts of barriers to getting to the point of taking antipsychotic medication. You know, people recognising that you are mentally ill, compelling you to have treatment, persuading you to have treatment, making a diagnosis. There's a whole body of research about the delay of the initial treatment of schizophrenia. And it's important because the duration of untreated psychosis is one of the factors that determine prognosis, along with an earlier age of onset and actually, you know, frankly, cannabis use is an important factor. You know, the, the psychosis emerging in the teens not long after exposure to cannabis is not at all uncommon, and I agree fully that, you know, by the time he presented he had schizophrenia.

DWYER: Dr Nielssen, at paragraph 58 you say, "A note from a referral call to a mental health intake dated 19 December 2000 included that Mr Cauchi had threatened a person by saying he had a gun in his bag". Is that Mr Cauchi Junior, that's Joel?

WITNESS NIELSSEN: Yes, I beg your pardon, yes, that is - and again, that's just taken from the Toowoomba Hospital medical records.

DWYER: By the time that Joel was making those threats and engaging in verbal abuse and aggression, they were symptoms of psychosis?

WITNESS NIELSSEN: Yes, he'd - it seems he'd had those symptoms. His duration of untreated psychosis was probably a little shorter than a year and it

seems that he got treatment fairly promptly after that. So he was admitted within a month of making that threat.

DWYER: I'll come to that first admission. He was admitted to the psychiatric unit of Toowoomba Hospital for four weeks from 27 January 2001 to 23 February 2001. I appreciate this is all set out in your reports, but I'm saying this so that everybody could follow it. I'm going to focus on Dr Nielssen for these uncontentious questions. If any of the panel members would like to add to that would you please let us know? Dr Nielssen, you write:

> "The discharge summary reported that he was brought to hospital after damaging doors at home and he believed he'd been possessed by demons for two weeks. A morbid change was reported from the age of 14. At the time of admission, Joel described hallucinations of frogs and of seeing and feeling demons entering his body, feeling as though his movements were controlled, and that people were inserting thoughts into his mind, and believing he was followed by two men.
>
> It was noted that Andrew Cauchi, Joel's father, had a psychotic illness. Joel confirmed the past use of cannabis but reported that he had not had cannabis or alcohol for 18 months prior to admission. He expressed anxiety", et cetera.

It was in fact Joel's father who called the police leading to his admission and he was supported by other family members. There is evidence at that early stage of auditory, visual and tactile hallucinations, is that right?

WITNESS NIELSSEN: Yes, I mean the, the syndrome, the combination of symptoms is, is very typical of, of, of an acute schizophrenic form of psychosis.

DWYER: The inpatient records include information from Andrew Cauchi in which he told staff that he took his son's threats to kill seriously. Is it common for members of the family, even though they love someone dearly, to feel genuinely frightened when this psychosis emerges?

WITNESS NIELSSEN: Yes, of course, and often because of, of the anger and hostility that accompanies these symptoms, and as Professor Nordentoft said there, the, the person themselves are in fear because of their symptoms and reacts angrily and, and again, that's the, the - there was other reasons perhaps Mr Cauchi's father took it more seriously but, but often family members are frightened of acutely psychotic relatives.

DWYER: Can that make it difficult for family members to report symptoms, or to get their loved ones help?

WITNESS NIELSSEN: Most definitely, and, and, and again I'm jumping way ahead to 2023, it seemed that his mother was a little bit circumspect about, about reporting her concerns because - perhaps because she was a little afraid.

DWYER: I'll come back to that issue. Staying with this early years of treatment, we know that Joel was an inpatient for four weeks at that period of time. He was managed in the community with the support of a Mobile Intensive Rehabilitation Team, or a MIRT. His symptoms continued. Dr Nielssen you note at paragraph 63:

> "An entry in the community mental health records from 19 June 2002 noted the presence of intrusive thoughts and indistinct hallucinations of voices and sematic sensations. There were symptoms of OCD in the form of repetitive cleaning behaviour."

This is OCD prior to Joel being trialled on clozapine. Was it evident to you that OCD, obsessive-compulsive disorder, was a symptom of his schizophrenia, as opposed to just a side effect of medication?

WITNESS NIELSSEN: Look, it's very hard to separate the two. They, they have overlapping inheritance, for example; tic disorder, obsessive-compulsive disorder, and psychotic illness appear in family histories separately or together. The, the classic textbooks on schizophrenia phenomenology describe obsessive-compulsive symptoms as being common in the, the, the onset of schizophrenia. I mean, it's really hard to separate the two. I mean, we know OCD is a kind of neurological disorder, some sort of - of some sort of neurological origin. And I, I think it's just part of the one syndrome.

DWYER: Does anybody want to add to that? I'll return to these symptoms of OCD at some stage as we track Joel through his diagnosis. Dr Nielssen, you note that Dr Nicky Stephens, who was his treating psychiatrist, or one of them, in the public sector, recorded on 21 August 2002 that

> "Joel's auditory hallucinations continued, but were not as intrusive or frequent. A subsequent letter noted the presence of auditory hallucinations, distorted perceptions of his body, poor concentration, and thought disorder.
>
> In September, Joel was invited to participate in an early psychosis group facilitated by a psychologist, and there was a further admission to the psychiatric unit of Toowoomba Hospital from 1 October 2002 through to 15 October 2002 to initiate treatment with clozapine."

Dr Nielssen, what were the first line antipsychotics that had been trialled with Joel from January 2001 through to October 2002?

WITNESS NIELSSEN: Yes, he was initially treated with olanzapine, better known by the brand name Zyprexa. And again, the doses weren't impressively high, and he was later switched to risperidone or Risperdal, and again, not very high doses. But it seems that he continued to have symptoms despite treatment with those two medications. And I'm sure that's what - and, and, and the, the other disability, the negative symptoms probably contributed to the

decision to initiate clozapine.

DWYER: In October 2002, a decision was made to admit Joel to hospital to commence the clozapine. The admission was for a couple of weeks at that time, and it was supported by community mental health follow-up. I'm going to just take you to some of the ongoing symptoms that appear to be reported after that time. Dr Nielssen, you note that in May 2003 Joel listed possible triggers to relapse as study, stress, the use of marijuana, and physical illness. Is it important, in the therapeutic alliance with a patient, to have them understand what their possible triggers are for psychotic relapse?

WITNESS NIELSSEN: Yes, of course, yeah. Especially too if those triggers could be minimised or avoided.

DWYER: Joel listed his own early warning signs of relapse as "being preoccupied, feeling as my thoughts would not be my own, or thinking that I could be someone else", and he set out his goals at that stage, "to join and successfully compete in competitive level shooting". Joel wrote that both hallucinations and suspicions he thought had gone by May 2003.

That was Joel's assessment of what might be warning signs. We know that that first episode of psychosis as you set out - as you all set out - was characterised by aggression, threats, and the auditory hallucinations, and also a disengagement or a lack of engagement with those close to him. When looking out for signs of relapse, is it important to look at the early signs of psychosis to see if they return? That is, do the early signs give you an indication of what might be a relapse in the future?

WITNESS NIELSSEN: Yes. In particular, a change in the emotional responses of a person, that they might seem more preoccupied or more irritable, rather than what they might disclose in terms of the return of symptoms.

DWYER: Does anybody want to add to that, or disagree with that? So far, everybody aligned.

WITNESS HARRIS: Just, I - I'd say that although they're an indication, they're not always 100% there. So, so the return of symptoms can, can be heralded by a broader range or a different profile of symptoms. But they are indicative of a return of the illness.

DWYER: Dr Harris, is it possible for patients, like those in Joel's condition, to not recall what the earlier auditory hallucinations or visual hallucinations were? That is, once they recover, it's difficult for them to identify it?

WITNESS HARRIS: It, it can be difficult too for some patients, because the period of time when somebody is acutely psychotic is very disorganised and is sometimes filled with sleeplessness or substance use or a whole range of other things that can interfere with the - with, with effective remembering of symptoms, as well as the fact that there is an effect upon memory itself with,

with the disorder. So, it can be difficult for people to clearly remember all of their symptoms.

DWYER: For that reason, is it generally accepted in practice that it's important to engage family members or those close to the person with an illness so that they can assist to recognise symptoms of relapse?

WITNESS HARRIS: Yes, it's very important to, to engage family members in, in, in the treatment and, and to use their, their experience and their knowledge of their, of their loved one in, in the treatment, as the family is, is going to be the, the chief ally of the person with - presenting at this sort of age, and the chief resource in the recovery journey.

DWYER: Professor Nordentoft, you spoke before the break about a particular clinic in Denmark that where, if you're going to wean somebody off antipsychotic medication, that clinic does the close follow-up for 18 months, and you spoke about weekly follow-up. Is it part of the protocol at that clinic to engage the patient's family members, or loved ones?

WITNESS NORDENTOFT: No, it's actually not. I, I think they often do, but it's not a protocol for doing it. It is a part of the protocol for the early intervention teams. We, we have specialised assertive early intervention teams where it's more or less mandatory to involve the relatives. And I, I think they often can convey very important information. They know the patients much better than, than really we should do as professionals. And they can often observe signs of early relapse long before the psychiatrist would be able to detect it.

DWYER: So it's good clinical practice to pay regard to those signs that are reported by family members, is that fair?

WITNESS NORDENTOFT: Yes.

DWYER: Just carrying on with some of Joel's symptoms, and then I'll come to his diagnosis at the end of 2012. Dr Nielssen, as with your colleagues, you set these out. For example, paragraph 72, skipping to 2006, reviews at the clozapine clinic noted Joel's denial of symptoms of psychosis, but the persistence of OCD and his continued involvement with an occupational therapist. On 22 February that year, 2006, an occupational therapist elicited an account of voices that Joel heard, attributed to god punishing him.

A family conference on 6 September 2006 noted that Joel had good insight into the nature of his auditory hallucinations if they occur, but poor insight into his obsessive thoughts of contamination. Dr Nielssen, did those auditory hallucinations and the contamination issues appear to be signs of ongoing psychosis at that time?

WITNESS NIELSSEN: Well, psychosis is defined as having a delusional belief, and I guess attributing voices to the voice of god is a delusional belief, and that, again, Dr McQueen, his case manager who was a psychologist, a PhD psychologist and something of an expert in OCD, I understand had, had

speculated that, that his account of obsessional thoughts may well have been hallucinations. And he did have - he was his case manager for, for, for nearly six years. So again, they, they could've been symptoms of psychosis.

DWYER: An entry on 8 January 2007 by Dr McQueen noted hallucinated voices to be present in varying frequency and intensity.

WITNESS NIELSSEN: Yes.

DWYER: Dr Heffernan, you deal with an entry in 2008 the following year at paragraph 2.17 of your report. You note that:

> "Throughout the remainder of 2007 Joel continued to experience positive psychotic symptoms and OCD symptoms. By mid-2008, his clozapine dose was 600 milligrams at night, and aripiprazole 15 milligrams. It was reported that while his negative symptoms were improving, it was noted in this clinical record he had experienced occasional auditory hallucinations and he'd developed the side effect of bed wetting."

Dr Harris, firstly, is 600 milligrams at night clozapine a high dose of that drug?

WITNESS HARRIS: Yes, it is.

DWYER: Is it common for somebody who has experienced schizophrenia in their teenage years to still have ongoing symptoms some, by this stage, four years or so after commencing clozapine?

WITNESS HARRIS: No, it's not common. Most patients, in my experience, have responded to treatment relatively quickly after the initiation of treatment.

DWYER: Does that tell us anything about the severity of the disease at that stage?

WITNESS HARRIS: It suggests that Mr Cauchi had a severe form of schizophrenia.

DWYER: Professor Large, do you agree with that?

WITNESS LARGE: Well, I have a slightly nuanced view. So, just going back to the question of how stable people's initial symptoms are. We use the term "first episode psychosis" because the diagnosis of schizophrenia isn't necessarily particularly reliable at the beginning of the illness, and some people who present with psychosis will subsequently have a mood disorder. And, and additionally some people who present looking as if they have a psychotic version of a mood disorder will end up having schizophrenia. So, we use the term "first episode psychosis" in that undifferentiated period.

In Mr Cauchi's case, it was quite clear that he had schizophrenia. He had an unusual pattern of, you know, persistent - a persistent first episode of

schizophrenia - and I'm not saying first episode psychosis, but he had this long episode that went on for years. That is a somewhat unusual but well described pattern. I think there's a framing issue to do with the severity that is probably influenced by my role in the public sector.

So, schizophrenia - anyone who has the diagnosis of schizophrenia has a severe disorder. And the most extreme forms of - most severe forms of schizophrenia are quite extraordinary. And in the public sector, Mr Cauchi wasn't placed in that category and was referred to the public - private sector as a result of that. So, I think his illness was enduring, you know, obviously very problematic for everybody. But in terms of his actual symptoms, was of moderate severity.

DWYER: Joel was described as stable by 2009. But Professor Large, you will have seen in his reports he continued to experience positive hallucinations right up until 2012 at his time of discharge from the public sector, is that right?

WITNESS LARGE: Yeah, lots of people are stable. But one-third of patients don't - I mean about a third of patients with schizophrenia do pretty well. About a third do sort of in - have some response to treatment and have some ongoing disabilities. And there's another third who are chronically severely disabled, perhaps in and out of hospital, having contact with the criminal justice system, using drugs, are persistently dangerous to their families, end up in public housing because they can't live with anybody else. I would put Joel in that sort of intermediate group really, rather than in the very severe group.

DWYER: One of the things that Joel had that some patients don't have is very supportive parents who were offering him accommodation, do you agree with that?

WITNESS LARGE: Actually, I would say that almost every child who develops schizophrenia has extremely supportive parents. I think that his parents were very supportive, and his mother was very, very active. But, but any child who develops schizophrenia will be of enormous concern to families. Families have bottomless needs that are often not met very well by the health system and, you know, as a result of that there's a group of people who don't end up living in their family home. But I think it would be wrong to think that the parents of other children with schizophrenia are not similarly concerned. It's a - it's - becomes the dominant thought process for the parents of anyone with schizophrenia. It's really - I, I, I tell my registrars that the families of people with psychosis have bottomless needs for assistance.

DWYER: Is there more need in Australia for support systems for family members?

WITNESS LARGE: No doubt. But, you know, things are worse in other places. They're much worse in the US. Much worse.

DWYER: I might come back to that in terms of recommendations. Professor Large, just to remind you - or remind everybody listening - Joel was

discharged in 2012 on a high dose of clozapine, 550 milligrams. In spite of that, and in spite of that treatment with very large doses of clozapine from 2009 to 2012, he continued to experience positive symptoms of psychosis. That suggests a serious form of that illness, doesn't it?

WITNESS LARGE: It suggests a persistent form of the illness, but all schizophrenia is severe.

DWYER: By 2012, at the time of discharge, Joel had been in the public health system from 2001 when he experienced those acute forms of psychosis through to 2012 where he'd been stabilised on large doses of clozapine but still experienced some positive signs of psychosis and negative symptoms of schizophrenia, is that right?

WITNESS LARGE: Yes.

DWYER: Does that suggest that at least by 2012 it's accurate to describe that disease as a chronic form of schizophrenia?

WITNESS LARGE: He definitely had chronic schizophrenia, absolutely definitely. And schizophrenia is a severe disease, or severe illness. But the public system saw fit to discharge him to the private system, and if - I mean, that indicates their view. And my view is that at that time, a patient similar to Joel - and I'm not necessarily talking about Joel - in the public sector in almost anywhere in Australia would be regarded as not being of the most severe - on the most severe spectrum.

DWYER: Sure. But Joel was discharged - we've got a note from one of the psychiatrists who was working with him around that time - the decision to discharge him in the public sector was influenced by a number of things. First, his stability; secondly, the fact that he and his parents were supportive of him being discharged to the private sector so he could have the psychiatrist of his choice ongoing; and third, because he was someone who was very compliant with his medication regime. Do you agree with that?

WITNESS LARGE: So, the most extreme patients don't meet any of those criteria. They've burnt their relationships with their parents--

DWYER: Sure.

WITNESS LARGE: --they won't take medication, and they won't come to appointments.

DWYER: But that was - the one factor leading to his discharge to the private sector was because he was compliant and cooperative, do you agree?

WITNESS LARGE: Yes, of course.

DWYER: Is it fair to say, Professor Large, there is evidence throughout that Joel wanted to be well?

WITNESS LARGE: Yes.

DWYER: And he wanted to have a productive life with positive relationships?

WITNESS LARGE: Yes.

DWYER: Do you see ongoing signs of negative symptoms of schizophrenia throughout the period of his treatment in the public and private sector?

WITNESS LARGE: No doubt. He had a very unusual psychometric test. So, schizophrenia, the old name for schizophrenia is dementia praecox. My belief is that schizophrenia is fundamentally a cognitive disorder. This young man - as a young man Joel obtained a scholarship to go to a private school, and later when he had psychometric testing, his verbal IQ was 129, which is not all that atypical of an IQ of doctors. There are, there are many doctors with an IQ of less than 129. Yet his performance IQ, which is, you know, doing your shoelaces up kind of IQ, was in the bottom 7th percentile.

So, he had this - he'd had a deterioration in some of, some of his cognitive functions, which was very significant, almost certainly due to schizophrenia, probably something - quite possibly something to do with cannabis. And so, he had an underlying cognitive deficit that could not have been remediated by medication. It just doesn't respond to medication really. And that would manifest as in his inability to - I mean he couldn't cook, the poor fellow. He, he had profound negative symptoms that I think were mostly due to his cognitive problems.

DWYER: And he's continued to experience those negative symptoms when he was not using marijuana, correct?

WITNESS LARGE: Marijuana, if you - marijuana causes cognitive impairment. It's entirely well understood and measurable if you smoke marijuana, for about six weeks afterwards you'll have impairments of memory, attention, concentration. There's some evidence of permanent disability of mathematical ability due to quite minor exposure to cannabis. More prolonged exposure to cannabis is - it's less certain what cognitive impairment occurs as a result of it, but it's quite likely that, that cannabis - chronic cannabis exposure causes permanent defects in cognition. This has been measured in rats. So, exposure to - if you expose adolescent rats to cannabis, they have permanent impairment in visuospatial learning throughout the rest of their two years of life.

DWYER: We haven't dealt with - you in your reports have each dealt with, I think, for the most part, the causes of schizophrenia, but there is a complexity, isn't there, in the relationship between cannabis and schizophrenia? Professor Nielssen, I might ask you because you and Professor Large both have an interest in this. Is it the case that sometimes people with an underlying schizophrenia can turn to cannabis to self-medicate, in effect? So that one comes - it's not that cannabis causes schizophrenia, but in fact somebody with schizophrenia might be more likely to use illicit

substances to self-medicate?

WITNESS NIELSSEN: Yes, well I mean it's a very common comorbid condition. I would say up to half of people in first episode psychosis have been smoking cannabis, and as Professor Large said, it brings on psychosis earlier. However, Mr Cauchi's cannabis use wasn't impressive, and he reported that he'd been abstinent for about 18 months prior to the initial treatment. However, the - again, we're jumping right to the end, but if he, if he had, and when he did resume cannabis, it almost certainly made his symptoms worse.

DWYER: Yes.

WITNESS NIELSSEN: Yeah, in between, I mean, the, the - it definitely leads to a less favourable course of illness, and, and also less adherence to medication, the cannabis and substance use in general. So, I mean it's a terrible comorbid condition.

DWYER: It's a risk factor that patients have to be warned about, and that treaters and family members would be conscious of?

WITNESS NIELSSEN: Yes.

DWYER: In terms of triggering. In Joel's case, rather than dealing with the general causes of schizophrenia - Professor Nielssen, if I can stay with you for the moment - Joel was diagnosed, or had those prodromal issues, from an early age in his teenage years. He was diagnosed with psychotic episodes at 17. His father Andrew had his own issues with psychosis. Is it possible, on your review of the history of Joel, to say what the cause of his schizophrenia was?

WITNESS NIELSSEN: Well, it's almost certainly an inherited, you know, neurological abnormality. Because it's not just his father, I think he's got an uncle, a paternal uncle who's a hoarder, and it's - so it looks like it's an abnormality handed down. However, despite our genome-wide understanding of, of genes, the specific genetic mechanism and the specific neurological mechanism for schizophrenia is not known. And obviously Professor Nordentoft is the international expert on this topic, but all I can tell you is it's probably an inherited neurological defect.

DWYER: Professor Nordentoft, can you expand on that, or do you agree with that?

WITNESS NORDENTOFT: Yes, I agree that there's definitely both twin studies and genetic studies indicating that there's a large amount of inheritability in schizophrenia. But also, it's also evident that it's not the whole explanation. There are also environmental factors that can affect whether schizophrenia will occur or not. And we've done a large register-based study indicating that cannabis use can contribute to the incidents of schizophrenia.

DWYER: Professor Large, before I come back to Professor Nordentoft, you

feel passionate about these issues in relation to the correlation between cannabis use and exacerbation of schizophrenia, is that right?

WITNESS LARGE: Well, I've looked at the science, so it's impossible not to be passionate about it.

DWYER: Do you feel that there's enough public understanding about that, or do you think when I return to recommendations it should be something that's more broadly understood?

WITNESS LARGE: I'm going to go a bit out on a limb here. The, the chief survival strategy of the cannabis plant is to make humans love it. Humans love cannabis, and it's the only drug that's managed to completely evade therapeutic regulation, and it's now got a therapeutic halo around it. But it is a potent - it is the most proven potent environmental cause of schizophrenia, and that occurs irrespective of your degree of inheritability. There's a thing called a polygenetic risk score, and there's an increase in the risk - in the likelihood of psychosis among people with a low polygenetic risk score, and it's similar among people with a high polygenetic risk score.

DWYER: Professor Nordentoft, is that similar to, or is that consistent with your research?

WITNESS NORDENTOFT: Yes. I, I would agree that cannabis is an independent risk factor as to schizophrenia, independent of the, the genetic risk. It adds to the genetic risk, but it can add also in cases where there's low genetic risk and a high genetic risk.

DWYER: Can I come to Joel's discharge from the public health system. If we could just have on the screen, please, page 327 of tab 793. These are the Mi-Mind Centre records. So hopefully you'll be able to see them too, Professor Nordentoft. You were provided with them previously.

Just to remind everybody, this was provided to the Mi-Mind Centre. The admission episode date notes 7 July 2003, which of course was not the first admission. Discharged 19 April 2012. There's a notation about:

> "Joel beginning to experience symptoms of schizophrenia in 2000 while in year 12, and that he became distressed by perceptual disturbances, including auditory hallucinations in the form of sounds and voices. He's been continually managed since then".

Down the page there's a reference to the fact that Joel had been stable since commencing on clozapine and had now been treated with clozapine for ten years. The next paragraph reads:

> "It appears that Joel may continue to experience some positive symptoms with fluctuating severity. However, Joel denies any positive symptoms. If symptoms are present, they're not interfering with his functioning. There was a brief period of exacerbation of

> symptoms around 2008 coinciding with a transition from Clozaril to clozapine at equal doses. That was managed by an increase in his dose of clozapine and the addition of aripiprazole. Negative symptoms remain a feature of his illness", et cetera.

Can I come now - and a question will follow - to page 333. This was the initial letter of Dr Boros-Lavack to Dr Grundy, a general practitioner of 6 March 2022. That letter lists Joel's diagnosis as chronic paranoid and disorganised schizophrenia in control on Clopine, OCD, and he was noted to be anxious, shy, with avoidant dependent features. Professor Nielssen, was that the appropriate diagnosis for Joel at that time?

WITNESS NIELSSEN: Yes. I'm not sure about the paranoid or disorganised categories, but certainly schizophrenia, OCD, anxiety and disability all - they're all quite - I agree with those.

DWYER: I think there's broad agreement that it's a chronic form of schizophrenia, is that right?

WITNESS NIELSSEN: Yes, yes.

DWYER: One of the vulnerabilities listed is that Joel's father is noted to be over religious with revelations. Can I pause to ask this question, Professor Nordentoft. In looking at the vulnerabilities, in spite of Joel's support from his mum and dad, would you expect a clinician to be aware that the fact that his father had experienced psychosis and was unmedicated would be an ongoing risk factor for Joel? Or might be?

WITNESS NORDENTOFT: Definitely, definitely one should be aware that he has this predisposition, but I think whether it had been there or not, it would - the, the clinical management of his case would be based on an evaluation of his clinical presentation. And, and of course also the knowledge that his father has this - that he has this revelations. But, but I think the, the main issue would be evaluating his clinical state.

DWYER: Would you be conscious of a risk that if his father was experiencing delusions, that could impact on Joel's mental health functioning?

WITNESS NORDENTOFT: Yes. I think that's necessary to consider. There is a condition called folie a deux where you are actually sharing delusions with people close to you. But I, I don't think that was the, the case with Joel's situation. But of course it is important to know that somebody close, close to a patient has a psychotic condition as well.

DWYER: I'll return to that potential influence in 2019 but before I do, in relation to how we characterise Joel's illness, Professor Nordentoft, do you say this at paragraph 47:

> "Together the mentioning of his symptoms in the medical reports, it is very well documented that Joel suffered from schizophrenia.

> Based on the fact that his psychotic symptoms were present for approximately a decade it must be evaluated that he was a typical case of severe treatment-resistant schizophrenia"?

And you've referred to the particular symptoms in the paragraph above. You go on to note at paragraph 82, "Mr Cauchi had a severe treatment-resistant schizophrenia and was treated with antipsychotic medication for 19 years. In the first 12 or 13 years he was still psychotic". So you are firm in your belief, Professor Nordentoft, that he can be characterised as having treatment-resistant schizophrenia?

WITNESS NORDENTOFT: Actually we discussed that in the panel before the - this, this court meeting and I, I think that for many years it - he fulfilled criteria for treatment-resistant schizophrenia, but actually he ended up with having some response to clozapine, and in that case, we - I would rather say that it is a chronic form of schizophrenia but it was - he was receptive. He, he did, he did have some response to antipsychotic medication, and in that case I, I think that it's more precise to call it chronic schizophrenia than treatment-resistant schizophrenia. So I'm deferring a little bit from what I wrote in the report. I'd rather call it chronic.

DWYER: Do you mean that at some point in time when the positive symptoms of schizophrenia have abated, you would shift in a diagnosis from treatment-resistant schizophrenia to chronic schizophrenia?

WITNESS NORDENTOFT: Yes, I think I would do that but it, it doesn't really influence a lot on the - on what kind of recommendations I would make regarding treatment. But of course if, if it was treatment-resistant after many years, one should consider whether the dose should be increased or whether it's - there should be some change in medication. But actually he responded well on the clozapine and the - and the combination of clozapine and aripiprazole.

DWYER: Professor Nielssen, can you comment on that in terms of the ongoing symptoms of Joel? He might be described as being stable in 2012 when he was given into the care of Dr Boros-Lavack, is that right?

WITNESS NIELSSEN: Yes, well it's in the sense that he hadn't - you know, he was adherent to treatment, was - there'd been no change in his level of symptoms for quite some time. Yeah, so, so, yeah, I would agree he was stable.

DWYER: He continued to - sorry, did I interrupt you?

WITNESS NIELSSEN: No, I was going to say nevertheless symptomatic to some lower level.

DWYER: That was my question. So what were his symptoms while he was with Dr Boros-Lavack, and I'm really going up until the time of June 2019 when all antipsychotics were discontinued?

WITNESS NIELSSEN: Well, well, the symptoms seemed to be the chronic cognitive symptoms and, and negative symptoms that were referred to by Professor Large, and, and very likely a lower level of, of, of hallucinations, although they're not documented, but they're very likely to have persisted. There's no reason they would've gone away even though his response improved. And, and then he had continuing symptoms of obsessive-compulsive disorder as well.

DWYER: Dr Heffernan, do you agree with that?

WITNESS HEFFERNAN: Yeah. I might add something--

DWYER: Please.

WITNESS HEFFERNAN: --if I may. So I don't disagree, but I just thought it was important to add the context of the term "treatment-resistant". It's not a term that's defined in the diagnostic and statistical manual. So it, it just - it's a term that's used really largely in, in relation to, for example, clozapine. So it - so it's just a definitional term really. It's - and it's, it's almost semantics in this case. But the, the, the term is defined by a failure to respond to two or more antipsychotic medications given in an adequate dose for at least six to eight weeks. And so by that definition, then you would use the term "treatment-resistant schizophrenia". That doesn't necessarily mean that someone doesn't go on to have a complete remission, a partial remission or never remit. It's just that initial period defines that term. Sorry.

DWYER: No, so that clarifies it. I think there's broad agreement then in terms of that definition now, is that right?

WITNESS LARGE: I was going to say exactly the same thing as Professor Heffernan.

DWYER: All right. At the time of discharging Joel from the public health system, if you can take it from me we've got a statement from Dr Manoj Narayanan - for the benefit of my friends, tab 781A volume 15 - and he says this, this is in 2012:

> "Joel was reducing the current daily dose of clozapine 550 milligrams due to the reported side effects. There was a slow reduction or tapering was suggested to a target dose range of 300 to 400 milligrams and then to check clozapine levels once he had reached a daily dose of 400 milligrams to ensure the dose was in the therapeutic range. Joel was to continue to take the aripiprazole while reducing his dose of clozapine."

Either Dr Heffernan or Dr Harris talks about how your preference would've been for Joel to maintain some sort of stable dose of clozapine, and I'll return to that shortly. Are there patients who are managed for the rest of their lives on a dose of something like what was envisaged by Dr Narayanan, which is

300 to - or 400 milligrams?

WITNESS HARRIS: Yes, there are, and I'd also draw attention to the introduction of aripiprazole to Mr Cauchi's treatment as that may well have helped significantly as an augmenting medication even though it is a very low dose of aripiprazole. But that combination of aripiprazole and clozapine is, is known to be an effective one.

DWYER: Why is that, in terms of the way the medications work?

WITNESS HARRIS: I don't think anyone really knows why it is. They're different classes of medications. Aripiprazole, along with its - the two other medications that are licensed for use from that class are partial dopamine D2 receptor agonists and that would appear to have some additional benefit, and additional benefit also from the point of view of negative symptoms.

DWYER: Can I come then fairly quickly to the first three years of Joel's treatment in the private sector, 2012 through to 2015. Does the panel agree that the Mi-Mind Centre setup was a good one, in that you had clinical nurses with training in mental health, a psychiatrist who was seeing Joel on a monthly basis and, if necessary or Joel was willing, a psychologist who could've assisted? I think there's broad agreement, do I take it, that that was a reasonable setup for management in the private sector? Professor Large?

WITNESS LARGE: Clozapine is very rarely prescribed in the private sector, and it's - I think it's impossible to be a sole prescriber of clozapine. You need to have that sort of setup, and the frameworks don't really exist. I, I don't know how many private clozapine prescribers there are in New South Wales, but not many at all.

DWYER: Dr Nielssen, I think you're a - could you tell us about your setup?

WITNESS NIELSSEN: No, I was the only private clozapine prescriber in Australia I think a - while in the homeless sector. But it was through using some - a number I got from St Vincent's Private Hospital I think I was able to do it. But everybody who started on it in the homeless sector made a good response, so it really encouraged me to want to use it more. The - I mean, the use of clozapine, the - 40% of the forensic patients who are on it, about 10 to 15% of patients in the community are on it and about 3% of the homeless patients were getting clozapine, and, and ironically they were the most, the most severely unwell who should've been getting it. So I guess that was the reason for wanting to do it.

But I, I thought the setup at the Mi-Mind Centre was exemplary in some ways. And the, the key benefit was to have the same doctor all the time or - and, and also for that doctor to have appropriate supports and coverage. It, it just, you know, guaranteed that, that, that you'd have a relationship where you'd assume the person would sort of follow the doctor's advice, you know, from building up a trusted relationship and - I mean, one of the reasons that clozapine might work so well is that the amount of clinical care you get,

because you, you, you have weekly blood tests which usually involves some kind of, you, you know, interpersonal conversation for people who are often very lonely. So, I mean, it's, it's sometimes hard to separate that from the, the medical effect of the medication.

DWYER: Dr Harris?

WITNESS HARRIS: I'd certainly agree that the way that Mr Cauchi was, was treated from the point of view of his medication at the Mi-Mind Centre was very good. However, there's a, a, a broader issue of, of psychosocial treatments that are a systemic problem for the treatment of people with schizophrenia, not just from the point of view of the treatment at the Mi-Mind Centre, and that is better - and that type of care of, of more assertive social skills training, of, of use of cognitive remediation therapy or specialist cognitive behavioural therapy is hard to obtain generally in, in this country. And that's not a specific but it is possibly more available in the, in the public sector in some parts of Australia.

DWYER: What's the ideal management for someone with Joel's condition with the severity of his illness as at 2012 in terms of an allied health professional response?

WITNESS HARRIS: It would've been best if he had access to a multidisciplinary team in which not only was his medication dealt with, and it was dealt with very well at, at, at the Mi-Mind Centre, but that he had access to allied health, particularly psychologists and occupational therapists, and a team also to help him get back into function. Mr Cauchi was attending university and had some real academic skills and was able to complete a degree, but it's, it's conspicuous that he was unable to, to follow that up with employment or with being able to stabilise his own life.

And that's the type of, of help - to bridge him into some form of employment to help provide a structure for his day, and to help him find a social network which would've been very protective, and particularly from dropping into homelessness - that was not available for him in Toowoomba and is often not available at all in this country.

DWYER: Where is it available?

WITNESS HARRIS: It's available in some specialist centres in, in - particularly in early psychosis programs which - or, or youth programs, but there's a, a gap for many people after they leave those more intensive treatment programs. There are some scattered programs which are linked to non-government organisations or to institutions like clubhouses that provide some social - a social framework for people to have continued connection with other people and to bridge into disability employment services of, of one sort of another. But that is, is patchy.

DWYER: Dr Heffernan, do you agree with your colleague Dr Harris?

WITNESS HEFFERNAN: Yes, I do. I think there's the what should be and the

what is. And I think that, just reflecting on your initial question which was about the Mi-Mind Centre, it was necessary at the time. I think that the public system is so overwhelmed, and to have an alternative where clozapine can be prescribed and a, a, a clinical nurse can be involved in the care and a psychiatrist providing regular treatment is a, is a, is a very good option. And - but is it sufficient? I would agree with Professor Harris that no, not ideally sufficient but necessary.

DWYER: Professor Large, is your evidence to be understood that your preference is for patients like this to be treated in the public system rather than the private system?

WITNESS LARGE: I think that is my evidence.

DWYER: Before I came to Professor Nordentoft, Dr Nielssen, have you provided clozapine primarily through the Matthew Talbot clinic, or also in your private practice at Level 8?

WITNESS NIELSSEN: No, I've got one - a very long-term patient, for 30 years actually, who takes clozapine, but he has it managed at Prince of Wales. He lives down there. But I've got six people on clozapine at my, my housing thing - project, which I'm - will assume I'll be managing long term. So, so it can be done.

DWYER: Through Matthew Talbot or through the private clinic?

WITNESS NIELSSEN: Well, they're all on the Matthew Talbot, which again is sort of - they, they believe is part of St Vincent's Mental Health, so - but that's how I do the, the, the blood reconciliations.

DWYER: Those persons are being managed on clozapine long term to good effect in minimising their symptoms?

WITNESS NIELSSEN: Yeah, certainly to, to better effect than other medications, yes, yeah. They've got treatment-resistant illness.

DWYER: But you gave an example of one patient, without giving any clues as to their identity, but 30 years managed on clozapine. Was that person previously, by nature of the fact that he's on clozapine - he or she - experiencing a severe chronic form of psychosis and illness?

WITNESS NIELSSEN: No, he had a very, very severe illness. He was living in the boarding house I alluded to earlier and he was on a - you know, massive medication, he was very angry and disturbed and I arranged admission to St Vincent's. And, and it was just remarkable, it was just a transformation and as so often - we so often see. And his, his actual regime has come down to 100 milligrams plus aripiprazole. He is fully employed. He still has, I think, chronic schizophrenia but, but we've certainly - he, he did try to go down to 25 milligrams and had, had troubling symptoms and we settled back on 100 and - so - but I, I would - I've always encouraged him not to stop.

DWYER: When you managed him down to 25 milligrams, was that in the private system still that he was managed down, or was that with the assistance of a hospital?

WITNESS NIELSSEN: No, I was corresponding with, with Prince of Wales, who were, who were managing his, his medication.

DWYER: How long did it take for those - were they psychotic symptoms that returned, or early--

WITNESS NIELSSEN: Pretty, pretty quickly, yes. So, anger, distress, hallucinations, prominent hallucinations, and quickly responded to restoring - he was on 300 long term, then it was reduced down and then down to 25 and then that wasn't, that wasn't correct.

DWYER: 100 milligrams might be thought to be a small dose, but you're saying that still on that - that small dose has proved to be an essential way to manage those symptoms?

WITNESS NIELSSEN: With aripiprazole.

DWYER: I see.

WITNESS NIELSSEN: And, and he's a very - not thoughtful man, but he - you know, he recognised his illness; he can identify his own symptoms.

DWYER: Yes, and so fully engaged in employment, did you say?

WITNESS NIELSSEN: Yes, yeah, open employment. Yeah. He's not on - he went off the pension, stopped smoking, I mean, you know, that's clozapine.

DWYER: Professor Nordentoft, in Denmark is it common for patients on clozapine to be managed in the private system or the public system or both?

WITNESS NORDENTOFT: I think most people would be managed in the public system. We have a very small private system and they are mainly dealing with people with other disorders. Most people with schizophrenia are managed in, in the public system, especially if they are on clozapine. I think a few private practitioners or private hospitals will be able - at, at the - at this point at least - to manage clozapine treatment.

DWYER: What is it about the public--

WITNESS NORDENTOFT: So I--

DWYER: I'm sorry. What is it about the public system in Denmark that means that this sort of care you need when you're on clozapine is appropriately provided in public rather than private?

WITNESS NORDENTOFT: I, I think it is the way we have organised ourselves. When I saw the Mi-Mind Centre, what they did would actually be quite parallel to what would happen in the public system in, in Denmark, except that we might have access to more of the services mentioned by my colleagues. For instance, to be able to be more assertive. I, I think that would also be a, a difficulty in the private system, to do that. At least the way we've organised ourselves in Denmark.

DWYER: What do you mean by "assertive"? Are you talking there about where there's early warning signs?

WITNESS NORDENTOFT: Yes. I, I think you would be able to do home visits, you would be able to involve the relatives and, and encourage them to report if there's warning signs, and be persistent if the patient is not attending planned visits. That's part of what I mean with assertiveness.

DWYER: I see.

WITNESS NORDENTOFT: But actually in the case of Joel Cauchi, he, he was attending almost every visit in the Mi-Mind Centre, and he complied with all blood tests and things like that. In that way I can understand that it was seen as an appropriate way of handling his, his situation. At least when he was stable. I think when he started to become unstable, the system - the, the vulnerabilities of the private system shows it's - this - the weaknesses became clear.

DWYER: Panel members, I'm going to take you to a letter in 2015 written by Dr Boros-Lavack to Dr Richard Grundy. It's dated 6 May 2015. It's page 240 of tab 793. While that's coming up on the screen, generally, is it fair to say that a decision was made - a reasonable decision was made by Dr Boros-Lavack to reduce the dosage of clozapine? I think the panel are in agreement about that. The panel are also in agreement, I take it, that there was regular correspondence from Dr Boros-Lavack back to the general practitioner, reporting on Joel's progress.

WITNESS NIELSSEN: Yes, yes.

DWYER: You will have noted that in that correspondence, Dr Boros-Lavack was telling the general practitioner that Joel was doing well and Joel's family regarded him as doing well. Is that fair?

WITNESS NIELSSEN: Yes.

DWYER: So in 2015, this letter is written and it includes that:

> "As you know, Joel has been very well for a long time, despite gradual reduction in his Clopine, which has decreased from 600 milligrams at night to his current dose of 275 milligrams at night by me with the continuation of Abilify, 5 milligrams in the morning".

I'll just pause there for a moment. Dr Nielssen, given that you've told us about that patient who is stable on 100 milligrams of clozapine, 275 milligrams at night with the assistance of Abilify is a dose which is therapeutic and was likely to be having a positive effect on Joel?

WITNESS NIELSSEN: Yes, very much so. That would be a typical long term maintenance dose.

DWYER: But the letter goes on to read he was started on clozapine at 17, and then she writes:

> "With the advent of Nicky" - that's Nicky Stephens - "coming to private practice, I have approached her to give a second opinion regarding Clopine. What would be his optimum dose? Could we switch him to another medication, eg, optimum dose of Abilify? I do believe Joel needs an antipsychotic for long term relapse prevention."

And Joel's mother was noted to be supportive of the second opinion from Dr Stephens. That letter of 6 May 2015, it's clear from the letter that Dr Boros-Lavack recognises that there is a need for - her belief at that time was that Joel needed an antipsychotic for long term relapse prevention. She's recognising the risk, she's getting a second opinion and she is, in accordance with the general standard care, that for somebody with his illness you're likely to need an alternative antipsychotic if clozapine is reduced. I'm trying to summarise to be quick, but is that - the panel are nodding in agreement?

WITNESS NIELSSEN: Yes.

WITNESS HARRIS: Yes.

WITNESS HEFFERNAN: Yes, agreed.

DWYER: Sorry, Professor Large, is that fair?

WITNESS LARGE: Yes, I just wanted to say, earlier you suggested I might have had some contact with the FDA. That's not quite true. I just wanted to correct that.

DWYER: Can I come to that?

WITNESS LARGE: Yes.

DWYER: I know that you don't want to present as having influenced the FDA in their decision-making--

WITNESS LARGE: That's right.

DWYER: --about clozapine. I'm grateful for that. We've printed something off about what the FDA are doing on clozapine in 2025, and I'm going to ask you,

Dr Large, about your opinion of that an what role you have played. Is it advising a group with an interest?

WITNESS LARGE: It is.

DWYER: I'll come back to that. In relation to Dr Stephens, might I then have the letter which is at page 86 to 87 of that same tab? The panel members will no doubt have had regard to this previously. Dr Stephens writes a letter back and in it she thanks Dr Grundy, who has done the referral on behalf of Dr Boros-Lavack. There's a couple of things I wanted to draw out from that letter. Dr Stephens has had a long-term relationship with Joel through the public sector. Is it fair to say, Professor Large, it was a very good idea for Dr Boros-Lavack to get a second opinion from Dr Stephens?

WITNESS LARGE: Excellent idea.

DWYER: Dr Stephens writes in that a couple of things. The second paragraph:

> "Joel's memory of his symptoms at the time of that relapse when he was aged 17 appeared quite patchy, but he could recall mostly tactile hallucinations of being touched on his back and believing this was a spiritual experience."

She goes on to note that "He did quite well on quite high doses of clozapine and his positive symptoms resolved completely. He said he's had no further relapse in the intervening 14 years". I'll just pause. That might have been recorded in this letter, but we know, of course, that there were symptoms of relapse while he was in the public sector, so he had not been symptom-free for 14 years, is that correct?

WITNESS LARGE: No, he hadn't been.

DWYER: He goes on to note, towards the end of paragraph 2:

> "Although there were no signs of positive symptom relapse, the family felt Joel became more withdrawn at this time. 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."

On the second page, the fourth paragraph up or the third paragraph up says:

> "His mother is agreeable to support him throughout 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."

That letter underscores, doesn't it - I might ask you, Dr Heffernan - that letter

underscores what is just good practice. That if you've got family members who are engaged and reliable, as Michele Cauchi was, you would pay careful regard to any signs that they raise in the future of concern?

WITNESS HEFFERNAN: Yes, I think that's really important because often, you know, in a first episode psychosis, the experiences that someone have are really poorly formed. Hallucinations are poorly formed, or they may be poorly formed. So to actually add meaning to them can be quite difficult and to understand them can be quite difficult and that may change over the course of illness. Also as people become unwell sometimes they don't recognise they're becoming unwell and in fact the process can be a recruitment of adversity in that the more unwell the person becomes the less they realise they're becoming unwell. And so that's why it's so crucial to have other people - particularly if they're as close as Joel was with his parents - able to recognise those early warning signs.

DWYER: Is it possible for patients who are clever as Joel was to mask their symptoms of relapse, once they've been off medication?

WITNESS HEFFERNAN: It's possible. People, when they are determined - it's just a human quality - when we are determined to achieve something we really want to diminish, maybe even dismiss, things that might suggest the alternative. And, you know, I - speculation, but I suspect that was - Joel was determined to, to remain well, wanted to push away, you know, symptoms and, and so it is possible that they - that he may not have voiced symptoms that were, were actually there. And, and I also think - perhaps if I could just talk about something else?

DWYER: Please.

WITNESS HEFFERNAN: I also think that, that the terms "stable", "well" and "remission" just need a little, a little context leading on from that in that, that terms are often defined or relative to the individual. So compared to being, you know, floridly psychotic, a person might be considered well with episodic attenuated symptoms, for example. But they're often not defined against the general population.

DWYER: Right.

WITNESS HEFFERNAN: And so it's really important to sort of take that into context when we see these terms in letters, we see "stable", "well" or "remission", sometimes they, they might mean relatively stable, relatively well, relatively remitted to that individual's previous state and may not reflect what that individual is like relative to the general population.

DWYER: I can see your colleagues nodding and somebody will let me know if anybody wants to say anything different. The other issue I wanted to ask you related to masking is if somebody has experienced side effects of medication - for example, low libido or OCD or any of the other side-effects that might come - would you expect to have a high index of suspicion that they might try to

cover up symptoms?

WITNESS HEFFERNAN: Well, firstly, let me say that most antipsychotics have unpleasant side effects, and it's perfectly reasonable to not want to have those side effects and, and I suspect that being on treatment with clozapine comes with a, a lot of side effects that are really unpleasant. And when a person is well, sometimes - or remitted - sometimes it's really difficult to understand that they could become unwell again. So, the notion that I'm on a, a medication that's causing me problems and I'm well, well that's a very compelling argument to say, well, I don't really need this medication.

And it happens all the time with other treatments, treatments of asthma, treatments for hypertension, for example, people in general are, are non - are often non-adherent to medication, because they feel like they may not need it. So, it's, it's also the same in this circumstance, except the side effects are often worse with antipsychotics.

DWYER: What's the education then that has to go on for a doctor to a patient to make sure they understand the risk versus the benefits?

WITNESS HEFFERNAN: Well, I, I, I think, you know, exactly that. That the key is education. We spent a lot of time with illness education, balancing those risks and side effects and benefits. And I think that's - you know, that - that's an, an ongoing process. It never stops. Because the side effects are ongoing - sorry.

DWYER: Does that mean that it never stops in terms of you need ongoing education for the patient, but also for the patient's family members? In this case, Michele and Andrew Cauchi?

WITNESS HEFFERNAN: Well, it seemed to me that Michele had a lot of understanding, from what I could tell, about mental health and was actively involved in, in mental health groups, and I'm not as sure about Mr Cauchi. But, but, but there will be moments in any family's history where they might change their mind or might think that, you know, this particular treatment is not necessary, and so that process of continued discussion is necessary.

DWYER: Let me get to the point then about Joel, before I skip forward, in 2019. In 2019, I'll come to the point shortly where I point out the symptoms that were being reported by Michele Cauchi, a decision was made by Dr Boros-Lavack that she would like him to go on an antipsychotic and he was advised about that. And then his father Andrew, when a practice nurse rang up, said that he did not want his son to go back on an antipsychotic, and then Joel did not go back on the antipsychotic. Does that suggest that there was a need to engage Michele and Andrew in understanding what the risks were for Joel of having been taken off his antipsychotic medication, Dr Heffernan?

WITNESS HEFFERNAN: It's a difficult question, because, you know, whether people might hold that view for different reasons. So if they hold it because of a lack of education, then education is going to be helpful. If they hold it

because of an ideological belief, or in fact an illness belief, then education may not be as helpful, and that - and that's why really considering the family unit as a whole is important. And of course, if, if his father did hold those views, that's going to be a very powerful message for, for Joel.

DWYER: I'll come to the exact notation shortly. Professor Nordentoft, did you want to add anything to the discussion thus far?

WITNESS NORDENTOFT: Yes, I think that the mother's concerns are being voiced very - they're very clear, both in letters and in the telephone contacts. And, and I think it is - I, I think it's not taken seriously enough in the autumn of 2019 where she several times reports being worried, and she reports that she's seen him - that his place is in a very messy state, and there are notes indicating that he might hear voices. And I think she's the best observer, and, and I think Joel might at that point be able - in short, or maybe also a little bit longer conversation - been able - be able to mask the real state of, of his mind. So that, that Michele's report might actually be the most accurate reflection of how he was at that time.

DWYER: I'm going to return to that, Professor Nielssen, shortly. Sorry. I'll come back to October 2019 shortly. Chronologically, we know that there was a second opinion in 2015 from Dr Stephens in relation to reducing clozapine or continuing to wean down from clozapine. I'll come to the decision to wean entirely off clozapine. Between 2016 to 2018, in general, Mr Cauchi was presenting well. There were regular letters from Dr Boros-Lavack to his GP indicating that he was presenting well, and some of those letters referred specifically to the fact that Michele Cauchi was supportive of him reducing his medication and reporting that he was doing well. Is that a fair summary? Sorry, Professor Large, did you--

WITNESS LARGE: So, in the letter of 2015 from Nicky Stephens - and this is the first entry that I can find about stopping clozapine - she says "I've discussed with Joel and his mother today the potential risk and benefits of stopping clozapine medication". That's the first time this emerges.

DWYER: Yes.

WITNESS LARGE:

> "The risk of relapse of positive symptoms, also exacerbation of negative symptoms and the attendant impairment of functioning and disruption of his ongoing study and lifestyle, the benefits of the trial off clozapine would"--

And she talks about the benefits there. So, that's where this is introduced into the file at least in the letter from Nicky Stephens. So that's the first thing I want to say.

The second thing that, you know, psychiatry always occurs in the context of uncertainty. That's really what we're dealing with. And to just take, take this to

some more neutral territory. It's very frequent that a patient will say they don't have suicidal ideas. When a patient does tell us they have suicidal ideas, that tells us something, but it doesn't tell you all that much. If psychiatry starts getting into the territory of, like, second guessing or thinking we can read the patients' minds, then, then we've become insane.

DWYER: Dr Large--

WITNESS LARGE: We have to listen to what our patients say. That's the primary starting point. There may be distractions from that, but that is the starting point.

DWYER: In that letter of Dr Stephens, there's a discussion referred to about the risks and benefits of stopping clozapine. The decision at that stage was very much that if clozapine was stopped, another antipsychotic regime would still continue, am I right?

WITNESS LARGE: Yes.

DWYER: There's no suggestion of weaning Joel off all medication at that point in time?

WITNESS LARGE: It talks about stopping clozapine.

DWYER: Certainly the letter that I took you to earlier from Dr Boros-Lavack in terms of the second opinion was that her aim was to determine what the optimal dose of clozapine was, or if there was another antipsychotic regime. But her belief as expressed in 2015 was that Joel would need to be treated on long term antipsychotics.

WITNESS LARGE: Yes, that was her belief.

DWYER: A decision is made in 2018 to remove Joel from the clozapine entirely, and I just come to that. Might I have page 170 on tab 793. This is the termination of treatment form filled out by Dr Boros-Lavack. If you scroll down please in that letter? Earlier, if you can take it from me, it says, "No event except discontinuation of Clopine due to successful treatment." And then "Ceased due to medical reasons", which are determined to be "recovered from first episode psychosis and remained well with no relapse over the past 16 years!" This is in 2018. 16 years takes us back to 2002. Dr Nielssen, that's not a correct characterisation, is it, at that stage, that Joel had "remained well with no relapse over the last 16 years"?

WITNESS NIELSSEN: Well, he - he's been, he's been pretty unchanged. And in fact, she's observed an improvement, according, according to her. There's been no acute relapse. There's been no acute admissions to hospital. There was the minor relapse in about 2007, 2008 with the changed formulation when there were more symptoms. But the only disagreement would be the characterising his illness as a first episode psychosis. It's a chronic psychosis. But no, I generally agree that she hadn't - he hadn't had a - an acute relapse.

DWYER: Professor Harris, do you agree with Professor Nielssen that it's not correct to describe it as first episode psychosis, but he hadn't had an acute relapse?

WITNESS HARRIS: Yes, I do. He, he - this is not a first episode psychosis. The - he has schizophrenia and it's a chronic illness. And he'd had continued symptoms for the majority of the 16 years that - over which he'd been treated with, with clozapine.

DWYER: Professor Nordentoft, I think--

WITNESS NORDENTOFT: Yeah, I - I'd just like to add to that. I, I think it would be wrong to characterise him as a patient with first episode psychosis. He's far beyond that. It is a chronic condition. And I also think it's slightly misleading to say no relapses, and of course there were no relapses, but it was because he was psychotic. So there could have been exacerbations. But, but he, he - it's not correct to, to state that there's been 16 years without relapses.

There's been 16 years, and in many of those years he has been actually psychotic. And for the last maybe four or five years, he was, he was not, or at, at least it was not detected. But, but he was not seen as psychotic over the last years and, and in that period you could say he did not have relapses. But before that, I think it would be wrong to call it no relapses, because you cannot have a relapse if you're already psychotic.

DWYER: Dr Heffernan?

WITNESS HEFFERNAN: Just really to reiterate that - the context of the word "well". And I, I think it - you know, if, if it's defined by a readmission to hospital, then that's why that word might be used. But, but if it's defined against the general population you couldn't use that word because you would have to say, you know, a period of negative symptoms, cognitive deficits, social deficits, and episodic psychotic symptoms.

DWYER: Do you agree with the view expressed by Dr Nielssen, Dr Harris and Professor Nordentoft that this is not described as a first episode psychosis by this point?

WITNESS HEFFERNAN: No, it's not a first episode psychosis.

DWYER: Professor Large?

WITNESS LARGE: Look, I agree. It's not a first episode psychosis, but he hasn't had a second episode of schizophrenia. So, it's, it's definitely not first episode psychosis, but he's had this prolonged fluctuating - I mean I hesitate to call it "first episode schizophrenia", but he hasn't had a second episode, and two comes after one.

DWYER: But I think you agreed that he suffered from chronic schizophrenia?

WITNESS LARGE: Yeah, of course.

DWYER: Can I ask you a question about the Abilify. Sorry, staying with the decision to remove him from all clozapine, Dr Nielssen, you express a view at paragraph 136 of your report. In relation to the decision to cease clozapine, in hindsight it appears obvious as a mistake, is that your view?

WITNESS NIELSSEN: In hindsight, of course, yes.

DWYER: What do you say about the decision to trial at least removing him from all clozapine?

WITNESS NIELSSEN: Well again, it's, it's - it seems to have been made very much with Mr Cauchi's wishes, and there, there seems there was a, a, a good and ongoing therapeutic relationship where maybe Dr Boros-Lavack was confident that if it was needed again it could be resumed. No, I, I, I don't disagree with, with, with going along with his wishes the way he, he was reported to be.

DWYER: Is it your view that Joel needed close monitoring from that period of time, given the risk of relapse that we've talked about this morning?

WITNESS NIELSSEN: Yes, ideally. And, and, and including after the cessation of Abilify as well.

DWYER: That's the view of the panel generally, as summed up by Dr Nielssen, is that fair? Dr Heffernan, you're nodding. Dr Harris?

WITNESS HARRIS: Yes.

DWYER: Dr Large?

WITNESS LARGE: Look, I think in the - after such an incredible event, we're all subject to outcome bias and hindsight bias, and beforehand we were subject to, you know, the biases associated with prospect theory. But it was within the guidelines, the College guidelines, further cessation of antipsychotics, if you go down. It goes all the way down to clozapine and then it goes back up to stopping if you'd been stable for two to five years. 90 - around 90% of the relapses will occur in the first year. So, you, you know, definitely should monitor for the first year. You know, it's a very tricky decision to think about it after, after the tragic events.

DWYER: Dr Harris, 90% of your statistics are that 77% of relapse will occur in the first year and 90% in the first two years. How long do you think that somebody should be closely followed up in Joel's position where you had had acute psychosis as a teenager and ongoing symptoms as described?

WITNESS HARRIS: One of the issues that's slightly complicating this is that

Dr Boros-Lavack reduced his medication to very low levels for some time before it was finally stopped. So, he was on 50 milligrams in July of two thousand - of clozapine - in 2017 and on 25 milligrams from January 2018. So, no-one knows exactly what his bottom therapeutic level was, but he was on a very low dose of the clozapine, which is likely to have been ineffective for a prolonged period of time. And so, in the middle of 2018 and, and, and when the date that the 12 month follow up should start is, is a little ambiguous, because he's likely to have been on a very low dose, and a possibly ineffective dose at that stage.

DWYER: He was on a low dose, but it was supplemented with Abilify.

WITNESS HARRIS: That's true. But it was also a very low dose of, of the aripiprazole, or Abilify, yes.

DWYER: Dr Nielssen's given an example of somebody who is being managed very effectively on 100 milligrams of clozapine.

WITNESS HARRIS: Yes.

DWYER: In that case, does that suggest that in fact very low doses can still be effective in managing--

WITNESS HARRIS: Yes, and that's also my experience.

DWYER: Professor Nordentoft?

WITNESS NORDENTOFT: Yeah, and I, I think we cannot know what would have happened if he would have stayed on a very low dose of clozapine, and we cannot know what would have happened if he would have stayed on 5 milligrams of aripiprazole. But the problem starts shortly after him being weaned off aripiprazole. So it, it could have been that just continuing on aripiprazole, I don't know, it would have been extraordinary if that would actually be enough. But it's, it's not impossible.

DWYER: Can I come then to the decision to stop Abilify. Sorry, just before I do, at page 85 of our documents we see a letter from Dr Boros-Lavack dated 1 June 2017 to Dr Grundy. That letter again expresses a view that, "Joel suffered first episode schizophrenia 17 years ago and has remained sustained full remission for the past 15 years on Clopine, which has been gradually discontinued." There's a collaborative decision, she notes, to wait another one to two months before the next medication regime.

Can I suggest to you that what we see in this correspondence is a continual referencing by Dr Boros-Lavack back to Dr Grundy that Joel is doing well, that he had first episode psychosis and that he's been in full remission and is doing very well. I'll come to the relevance of that again shortly.

So, the Abilify was stopped in June 2019, and we see a reference to that on 12 June, page 31, "Seen with mum re stop Abilify 5 milligrams in the morning.

Mum agrees that since Clopine was stopped a year ago, his son has become totally well with remission of his psychosocial disability". I pause to note, Dr Nielssen, there's clear reference to the fact that Dr Boros-Lavack has high regard for what mum is noticing at that time, in terms of him doing well, do you agree?

WITNESS NIELSSEN: Yes, yes.

DWYER: It goes on to say, "He's been caught up with his development delays". It records this:

> "Only problem has been residential complex tics involved in his sternocleidomastoid muscles causing his neck to turn involuntary to the right with associated facial and ocular grimacing. His tics were worse on Clopine."

We go on in the records throughout 2018 and 19 to see that Joel's tics come and go, but at some point are such in 2019 that it might be an indication that Joel, or Dr Boros-Lavack feels that he might be hearing voices to one side. What relevance are the tics, Dr Heffernan, to trying to understand whether or not Joel is experiencing a relapse?

WITNESS HEFFERNAN: Well, the, the tics are a, a difficult thing to assess. And I think we have to put a differential diagnosis around those tics. We, we read about them, obviously none of us have seen them. But the differential diagnosis would include that, that this is a true motor tic disorder, and in someone who's got schizophrenia, who's got OCD, there is an overlapping Venn diagram of these problems. So that's, that's one.

Number 2 is that the tics are related to antipsychotic treatment, and number 3 is that the tics are actually a mannerism that's associated with experiences of psychotic symptoms. So we have to - and there's probably 4 and 5, which I haven't thought of, but others may, but - so we have to sort of broaden our thinking about what actually are these tics, and the context is going to be relevant, so if - and the appearance of them will be relevant. So, it's possible that they could reflect a psychotic process.

DWYER: Can I take you to an entry on 28 November 2018. I might just continue with this, unless your Honour wants me to stop?

HER HONOUR: No.

DWYER: Page 35, 28 November 2018. This is a consultation with Dr Boros-Lavack. It says he presented for a face-to-face appointment. "Joel seems out of sorts, apparently upset after appointment with Dr Boros-Lavack". Sorry, that's Andrea Brooks, the nurse noting that, and saying, "Discuss with Dr Boros-Lavack. Mother has contacted this service today concerned that Joel is out and about too much, never home. She feels it's too stressful an event for Joel to consider study for community services", et cetera. If you could look at page 36, there's a consultation note of Dr Boros-Lavack. "He presented well,

energised and confident, but also vulnerable". She later goes on to note:

> "He's keen to meet a girl that he can marry and start a family with. Mental state was apsychotic, euthymic, but exhausted, with a new mannerism of a complex tic of frowning towards the right and then bringing his gaze back into the conversation like he was responding to an NAS".

What does that acronym stand for, Dr Heffernan, "NAS"?

WITNESS HEFFERNAN: I was hoping you wouldn't ask me that question. I'm thinking that, that it's a "not apparent stimulus", but I, I, I could be wrong there.

DWYER: Do your colleagues agree? That's what makes sense, or something like that--

WITNESS LARGE: Something like that.

DWYER: --makes sense in the circumstances.

> "When confronted, he was grateful for it and explained his behaviour of fighting with breaking down emotionally, then cried with his head down from exhaustion as he's been well aware of doing too much".

This is - he's on Abilify 5 milligrams in the morning still at this stage, but he's been off clozapine for about 18 months. What would you make of - sorry, 12 months altogether. What would you make of those symptoms, if anything, Dr Heffernan?

WITNESS HEFFERNAN: Well, you know, anyone that, that has an apparent tic, that's a concerning thing to, to start with. The second thing is the way that that's described in Dr Boros-Lavack's entry makes me think that the differential should be reshuffled such that at the top of my differential is, well, maybe this is a psychotic symptom. Because in the context he's no longer on antipsychotic medication, it's suddenly reappeared, and, and the description suggests that rather than the phenotype of a tic, it's more a gaze and a concern - concerned look which disengages him from the conversation. So that would be more consistent with a, a psychotic symptom. But I think we just have to put a caveat around that to say that none of us would, would, would be certain.

DWYER: All right. Something to closely monitor, but you couldn't be certain what that involved. Do your colleagues agree with that?

WITNESS HARRIS: Yes.

WITNESS NIELSSEN: Mm-hmm.

WITNESS LARGE: Can I--

DWYER: All right. I'm going to jump forward then - I'm sorry, I beg your pardon.

WITNESS LARGE: I mean if a, if a patient with schizophrenia on antipsychotics, even if they're having a reduced dose, presents with a movement disorder, the most common explanation for this is that they are developing tardive dyskinesia, or even tardive dystonia. That's the single most probabilistically - I mean there might be some things that you observe about it that make it think - make you think that it's something different, but he's had nearly 20 years of exposure to antipsychotics. He may well have had a withdrawal emergent tardive dyskinesia or actually--

DWYER: Can you explain that in layperson's terms, please?

WITNESS LARGE: So tardive dyskinesia is an involuntary movement disorder that occurs as a dose response curve to antipsychotic medications. Older antipsychotics are more likely to cause it than newer antipsychotics, but older antipsychotics had an incidence of about 5% per year. Typically, it involves orofacial movements that are - you know, they're, they're lip smacking, blinking, involuntary movements, pill rolling of the fingers. It's a real problem with older antipsychotics but is not unknown in newer antipsychotics.

It's - most patients who have schizophrenia are actually not very aware of it and it doesn't trouble them particularly, unlike patients with mood disorders who it's often extremely troubled by it. It's socially stigmatising. It tends to get worse. It is dose dependent, so the more antipsychotics you're given, the more likely you will develop tardive dyskinesia, and there are people who have such severe tardive dyskinesia that you make a judgment that they should be off antipsychotics and tolerate their auditory hallucinations.

DWYER: Would you expect to see that when Joel had been off clozapine, and on your evidence on a very low dose of clozapine such that it might not work, some two years later?

WITNESS LARGE: You might not expect to see it, but you wouldn't be at all surprised.

DWYER: All right.

WITNESS LARGE: But I still maintain that the most probable explanation of a tic disorder in any patient with 20 years of exposure to antipsychotics is tardive dyskinesia and not a psychotic symptom.

DWYER: Dr Harris?

WITNESS HARRIS: Well certainly I agree that with any patient who's been on antipsychotics for a prolonged period of time, tardive dyskinesia or a movement disorder caused by the antipsychotics is a real possibility. Clozapine is the antipsychotic least likely to cause this particular disorder, and

in fact one of the reasons for starting someone on clozapine is significant movement disorders such as tardive dyskinesia. Aripiprazole in, in my, in my experience can cause tics such as this, and I think it's actually more likely that it was, if anything, due to the, to the aripiprazole. Clozapine has a very low, low propensity towards causing tardive dyskinesia.

DWYER: Professor Nordentoft?

WITNESS NORDENTOFT: Yeah, my, my first thought was that it could be tardive dyskinesia, and it's - actually clozapine is sometimes used to treat tics. So, I, I think the fact that it occurs after clozapine being tapered off, it does not - it, it does make it likely that it is tardive dyskinesia. And I also think that the description of the sternocleidomastoid - the muscles, it is, it is in agreement with the, the suspicion of tardive dyskinesia.

DWYER: Professor Nordentoft, what about the--

WITNESS NORDENTOFT: But..(not transcribable)..whether it could be, it, it could be hallucinations as well, but I, I think tardive dyskinesia would be the most likely.

DWYER: What about the level of distress that is reported by Joel and recorded in that note that appears to be an unusual sign. Would you be concerned about that as a psychiatrist in terms of the return of symptoms?

WITNESS NORDENTOFT: I, I would be concerned, and I would think that feeling stressed is - it increases your vulnerability for a psychotic relapse. So, I, I would definitely be concerned.

DWYER: I come to one of the main issues. I'm going to present to you a list of the symptoms that are noted around the time of September, or beyond September 2019, and ask for your opinions separately after that. Can I bring to your attention that in September 2019, Joel was reported to have difficulty sleeping. So just a reminder that Abilify had been ceased by June 2019. That's, for the benefit of my friends, at page 29, "20 September, reported difficulty sleeping".

I'm going to go to until 1 o'clock unless anybody stops me. I'm getting some mutterings about a break, your Honour. I'm about to go to the point where I put to the panel the evidence of Joel's decline from September 2019 through to February 2020. What it might be helpful to do is to take the break now and to ask the panel if they would mind to refresh their memory over the break of the details of that, which appear at page 141 and 142 of the clinical notes, and page 20 through to page 27 of the clinical notes. Would that be convenient, your Honour?

HER HONOUR: We'll take the break. Can we come back at 1.30 then?

DWYER: Thank you, your Honour.

HER HONOUR: Thank you. We'll have a break.

LUNCHEON ADJOURNMENT

DWYER: Panel members, before I ask you some questions about symptoms noticed from September, I note that if you take it from me that at page 115 of the clinic volume there's a note to Dr Grundy from Dr Boros-Lavack which says:

> "Seen with mum re stopping Abilify 5 milligrams in the morning. Mum agrees that since Clopine was stopped a year ago son has become totally well with remission of his psychosocial disability, et cetera. The plan was then collaboratively decided to stop Abilify 5 milligrams in the morning."

I started before the break to run by some symptoms. Some three months later on 20 September 2019, a nurse notes, "Sleep not as good lately. Had melatonin. Cut it back. Mood good". On 17 October 2019 Dr Boros-Lavack saw Joel. If you take note of this date in particular and some others that I'll point out to you until March. 17 October 2019, Dr Boros-Lavack:

> "Seen with Brooksy re mum's concern for relapse. Joel's mother rang admin and reported her concern for Joel's mental health and physical health and she told Joel to keep the appointment after he had cancelled it".

Dr Boros-Lavack when she sees Joel feels that he's good mentally, but mum had raised that concern. On 31 October and 7 November Joel was seen by nurses and they did not see any signs of mood disorder or psychosis. If you could take note of this date. On 12 November Joel sent an email to the Mi-Mind Centre. It said:

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

He lists them all and includes images. On 14 November, two days later when Dr Boros-Lavack saw Joel, she was records that he was insomniac. He accepted a short dose of Zopiclone for sleep. He said, "Wants to stop use of pornography. Opposed to religious beliefs. Email noted and discussed. Given information on how to block sites".

Before I come to the other symptoms that he experienced from that time, the email that he sent on 12 November, does the panel agree, is the first of its kind to the reception, that is Joel reporting his own concerns in relation to his use of pornography and later reporting that it conflicts with his religious beliefs and was causing him stress and he wanted help removing it from all devices?

Dr Nielssen, if this was your patient who had been seeing you for some time given his background of schizophrenia, would you be concerned about his own reports of excessive - of use of pornography and how he was keen to block it?

WITNESS NIELSSEN: Look, it's hard to say generally. I'd really have to, you know, think about the patient, the individual in front of me. I mean, it seems unrelated necessarily to psychosis. But being communicated with for the first time suggests some sort of change.

DWYER: Is this fair to say: rather than pulling out individual signs or symptoms it's important to look holistically about what some of the indicators might be towards a decline in mental health?

WITNESS NIELSSEN: Exactly.

DWYER: The panel are nodding. I take it that that is uncontroversial, is that right? In relation to this issue though of pornography, there are many people in the community who use pornography legally and without criticism, but in this case is it significant that Joel was reporting that he was potentially stressed by it? That is, he wants help removing it from his devices, which suggests some sort of compulsion, and it conflicts with his religious beliefs which might cause stress? Is that fair, Dr Nielssen?

WITNESS NIELSSEN: Yes, yes.

DWYER: Does the panel agree with that? Professor Large?

WITNESS LARGE: Yes. One other thing. Antipsychotics can raise your prolactin level which has effects on sexuality.

DWYER: Sorry, Professor Large, could you speak up?

WITNESS LARGE: Sorry. Antipsychotics, including low doses of - all antipsychotics can raise your prolactin levels.

DWYER: What does that mean in lay person's terms?

WITNESS LARGE: It - well, prolactin used to be - dopamine used to be known as prolactin inhibiting factor when I was a medical student, and so raised prolactin levels do change your sex drive and it's possible that there was an emergence of his sex drive once he'd stopped or was stopping antipsychotics.

DWYER: Professor Nordentoft is nodding behind you, Professor Large. That corresponds with your understanding of the research, Professor Nordentoft?

WITNESS NORDENTOFT: No. I, I think that decreasing libido is a common side effect from antipsychotic medication, and when he's then weaned off, it's likely that his sexual desires will come back.

DWYER: Was that, Professor Nordentoft, something that his mental health

professionals, particularly psychiatrists, had to be wary of given the potential conflict that would cause in Joel because of his religious beliefs and the compunction to look at pornography?

WITNESS NORDENTOFT: I, I think actually to be attentive of the sexual desires and, and sexuality all through the treatment should be something that you should, you should be aware of. Also because for many patients it is, it is a reason why they want to stop antipsychotic medication, because it impedes sexual life. So I think there should be attention to it both while patients are treated, but also when treated - when treatment is terminated.

DWYER: There is of course a healthy sexual interest and an unhealthy sexual interest. Professor Nordentoft, would you expect that to be a concern of his psychiatrist given the extreme symptoms that he'd experienced previously, which included threats of violence back in 2000 and 2001?

WITNESS NORDENTOFT: Of course I think it is a warning signal, but it's very unspecific actually. So I'm, I'm not sure how, how much attention I would pay to it. I - but there are several. It's also the fact that he suddenly wrote a text message to the other psychiatrist asking about men's sexual performance and that was inappropriate, I think. You would think that something's going on. And we know from his tone that later on, a lot is going on, but we do not have records from his phone already in 2019.

DWYER: No, but in January, we don't know what his phone said at that - what it might've revealed, but in January of 2020 was the text message to the psychiatrist Dr Alempijevic when Dr Boros-Lavack was away, but that was an odd text message about sexual performance, and seen on the back of that email that he sent in November about concerns about pornography was a red flag. Is that fair to say, Professor Nordentoft?

WITNESS NORDENTOFT: Yes.

DWYER: Let me just come--

WITNESS NORDENTOFT: A rather unspecific red flag, but it is a red flag.

DWYER: Let me put it together with some other red flags. Can I suggest to you on 20 November - I withdraw that. Going back a step. 17 October he was seen with a nurse and his psychiatrist in relation to mum's concern for relapse. On 14 November he was seen by Dr Boros-Lavack in relation to and reported insomnia and wanting to stop the use of pornography. On 20 November his mother sent an email to Dr Boros-Lavack which is at page 141 which read - that can come up on the screen, if we may - page 141:

> Hi, Dr Andrea. I'm contacting you about my son Joel Cauchi. He isn't doing very well since going off Abilify, and I know you thought it wasn't having an effect, any effect, but I have noticed a gradual decline in his condition. And judging from notes on paper he's left around the place in the past week I have a feeling he's now hearing

voices, et cetera. He's very distracted, forgetful, and the OCD is getting out of hand with him going through half a cake of soap in one shower.

He found out last week that the place where he volunteers teaching English put someone new on and he'd been hoping to get a job there, so that was a real blow. I would hate to see him have to go back into hospital after 20 years of being stable when on medication, but of course being off it has made him realise how sedating it was, although I think that it was the clozapine that did that, not the Abilify.

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

I'm going to read you a clinical note after that, but in this, Michele raises "He isn't doing very well since going off Abilify". Judging from notes around paper left around the place in the last week she had a feeling he was now hearing voices. He was distracted, forgetful, and the OCD was getting out of hand. She reports a gradual decline in his condition. On 20 November 2019 there's a record of a consultation with the nurse. Page 25.

"Reports from those known to Joel of changes in behaviour. He's having extreme OCD with showering and washing himself, using half a cake of soap during one shower, writing a lot of notes plus, plus, plus at home and leaving them about. Mother read some notes with content of under satanic control, of religious themes, desire for porn with conflict of his religious beliefs and wanting to access porn. Leaving his phone with his mother at her home overnight so as not to use phone internet for porn sites.

Mother reports he is walking funny, change in his gait. He reports he's afraid of getting sick and wearing layers and layers of clothes to prevent getting sick. He's been observed that he bends his head a lot and has odd movements. Reports he's very busy but unsure what he's doing with his day. Wanting connection and relationship.

Mother does not want Joel to know she's raised concerns of deteriorating mental health with staff. Possibly hearing voices has been considered. And staff at the clinic noted unusual new behaviour with respect to his coffee drink - wanting coffee."

I'll just pause there. Does the panel agree that this sort of behaviour reported from mother is very different to the reports of Joel when he was well, including

as at June 2019 as reported back to the general practitioner? Dr Harris?

WITNESS HARRIS: Yes, yes. They - they're - they suggest that he is having a relapse, that he's having changes in his behaviour that suggest not only positive symptoms but a, a relapse of his obsessional symptoms. But also of the movement disorder that is highlighted earlier about - by Professor Heffernan as one of the symptoms of, of psychosis.

DWYER: Dr Heffernan, do you agree with your colleague Dr Harris?

WITNESS HEFFERNAN: Yes, so I had examined, as I'm sure everyone did, this period quite closely.

DWYER: Yes.

WITNESS HEFFERNAN: They're all subtle things. So each one of their own could be dismissed, although some of them are much more concerning than others. But when we collectively put together - and I counted nine different entries that were entries of, of concern either about insomnia or mother suspecting symptoms or change in behaviour, satanic control, preoccupation with religious themes. When you, when you start to put them all together, to me this is - flags well, you know, we're probably having a psychotic relapse here.

DWYER: When you say nine different entries, do you mean in that one medical note or from September through to February?

WITNESS HEFFERNAN: From the period of August 2019 until February 2020.

DWYER: Professor Nordentoft, do you have anything to add to that? Do you agree with your colleagues?

WITNESS NORDENTOFT: Yes, I agree that there are several red flags and I think the most important ones are the concerns raised by his mother, who is the one who know most about his, his condition. Much more than can be revealed through a rather short conversation with a psychiatrist or a registrated(as said) nurse. I think there is a missed opportunity in this period because actually the nurse had a discussion with him where he agreed to start antipsychotic medication--

DWYER: Yes.

WITNESS NORDENTOFT: --and it should have been reintroduced at that time.

DWYER: Yes. I'll come to that shortly. You recall one of the notes there that was raised by mum in her email and then in the consultation is that she had "Found a lot of notes plus, plus, plus at home and leaving them about. Mother read some of those notes with some content of under satanic control, of

religious themes". And she reported her concerns that he was hearing voices. When Joel had his first episode of psychosis, the panel will recall what I took you to this morning: that on January 26, 2001, he put a hole through the flyscreen door claiming he was distracted by demons. He was observed scratching and to pull out a demon or devil. So those satanic voices and the agitation were features of his first episode of psychosis. Does that make it particularly concerning that mum is reporting satanic notes?

WITNESS NORDENTOFT: Yes, I think it's not always that the same system - the same symptoms reoccur when there is a relapse, but the fact it is exactly the same symptoms is really concerning.

DWYER: I am conscious of moving through the evidence, but Professor Large, do you agree with that?

WITNESS LARGE: Look, they were concerning things that required some further investigation.

DWYER: The next day, when Joel is seen in the clinic by RN Brooks, he's seen by a nurse initially, not Dr Boros-Lavack, but when he is seen by a nurse, she notes under "Examination":

> "Usual dress presentation. Well groomed. Poor eye contact. Evasive, indirectly answering questions, long replies, only vaguely answering questions. Denies hallucination, denies thought issues, confirm memory issues, short term memory. Looks to the left side often quickly, with eyes pointing up. Nil tics observed. Joel has difficulty explaining himself and repeats his words, speaks slowly and deliberately with no substance to topic. Skirts around the issue. Thoughts preoccupied, not expansive, denies themes, complains of excessive tiredness."

Does that suggest that the nurse herself is also noticing some red flags?

WITNESS LARGE: It does. But it, it - look, it does. But she wasn't able to elicit hallucinations or delusions. So it was - it's sort of intermediate, a bit of an intermediate result.

DWYER: You just heard Professor Nordentoft say that the mother, who was regarded as a reliable historian and helpful, the mother would have been in a better position to notice that than a short-term clinic assessment, do you agree with that?

WITNESS LARGE: I think that you - at the end of the day, you know, you've got to take the information from the patient and from other sources. And then you've got to be able to explain to the patient why you're doing what you're doing. And that was a bit tricky, because there had been a, you know, "please don't tell Joel this". So I think that did inhibit that conversation. This is a voluntary patient. I think they were in a process of gathering information at that point.

DWYER: The evidence thus far is that Dr Boros-Lavack and the nurses took the mum's concerns at face value. That is that they regarded her as a reliable historian.

WITNESS LARGE: Yes, yes.

DWYER: And do you see there under "Plan", "Joel is to return again the next day after thinking about his ADLs and self-reflection". Can you help us with the acronym of ADLs?

WITNESS LARGE: Activities of daily living.

DWYER: Thank you. This at page 25, Dr Harris, "He wants peer support, has next appointment. He agrees with the reintroduction of psychotropics but desperately wants to avoid sedation." The panel will have seen that although he didn't see Dr Boros-Lavack on that day, RN Brooks had a conversation with Dr Boros-Lavack and the plan recorded is "Abilify tablets, 10 milligram, one in the morning". The evidence from Dr Boros-Lavack is that that's a typographical error and she had intended half of that, 5 milligrams, although she had never written it that way previously. But regardless, there was a plan to return to Abilify.

Joel appears initially to have agreed with a reintroduction of psychotropics. And then you'll see page 24 there is something that occurs subsequently, but I'll just pause there. In relation to persuading Joel at that time to take antipsychotics and Abilify at 10 milligrams or 5 milligrams, Dr Harris, was that an appropriate response to the concerns?

WITNESS HARRIS: That was a reasonable response to restart medication and to, to restart aripiprazole as it represented the easiest path back into using an antipsychotic medication. Both Dr Boros-Lavack and, and Mr Cauchi had gone through several years of trying to stop medication, and to restart at this stage was really something which - I'm sure Mr Cauchi didn't want and it's also a defeat, I suppose, in some ways for the treating team that this would have been very, very disappointing for them at that stage. But the choice of aripiprazole at 10 milligrams would have been a standard starting dose for somebody with a psychotic illness.

DWYER: Sorry, 10 milligrams was the starting--

WITNESS HARRIS: 10 milligrams would have been a - the standard dose to commence for somebody with schizophrenia who was, who was not on medication.

DWYER: If the decision is in fact 5 milligrams, because she had intended to have a half tablet, would that have been appropriate or not?

WITNESS HARRIS: He had been on 5 milligrams and been well, so it's - in Dr Boros-Lavack's experience, it might have been that that was a reasonable

dose, that he'd stayed well for, for a continuing - for quite a prolonged period of time. But to restart medication is to - is, is the important point at this stage.

DWYER: Would you consider at that time going back on clozapine as an option, given the severity of the symptoms as reported by mum?

WITNESS HARRIS: Not necessarily. I think it would have been reasonable to, to trial an alternative medication at this stage, and recommending clozapine is a process, it requires baseline testing, they wouldn't have in fact been able to start clozapine just with a script. It would have taken probably at least ten days before they - the bureaucracy of starting clozapine would have been completed. So starting with the, the medication that he'd last been on is a reasonable one.

DWYER: Dr Harris, for a patient who has been doing well or appears to be doing well and then has an apparent relapse into psychotic symptoms, does it make more sense to you to put them on a 10 milligram of Abilify if you believe that these are psychotic symptoms?

WITNESS HARRIS: Yes, it does.

DWYER: Professor Nordentoft, the plan at that stage was to reintroduce psychotropics, which Joel initially agreed to on that day, and to have him followed up on a weekly basis by the nurses, and to have Abilify either at 5 milligrams or 10 milligrams. Dr Boros-Lavack did not actually see him in person until 8 January. She did not see him until about a month and a half after 20 November. Just taking - and I should say Joel then changed his mind and said that he did not want to go on medication. Was that sufficient response at that time to what mum had drawn attention to?

WITNESS NORDENTOFT: Well, I think that might be the situation where the vulnerabilities of a private system would be obvious. I don't know if - what, what kind of options they have had, but I think if I was presented to something like that, I would have put quite an effort to try to persuade him to really start and also monitor if had happened. And I think 5 milligrams is better than nothing, and given that he was very eager not to have something that was sedative, I think Abilify would clearly be better and I, and I agree with Dr Harris' concerns regarding starting with clozapine. That would be far too difficult.

SPEAKER: Your Honour, I think, I think--

WITNESS NORDENTOFT: So I think it was an appropriate answer to say start with 5 milligrams and - but monitor it closely and make sure that it actually happens.

DWYER: All right.

HER HONOUR: Just one moment.

LYNCH: 28 November was the consultation before January 2020.

DWYER: Do you have the notes in front of you, Professor Nordentoft? And sorry, Dr Harris does. You can see there - I misspoke and said January, but it appears there that there's a note 28 November 2019. It's a clinical consultation with RN Brooks.

WITNESS NORDENTOFT: Yes.

DWYER: And the note there is "Clinical at 2.40", so he's seen initially by RN Brooks at 3.17 and then seen by Dr Boros-Lavack a week after mum's concerns. I'll come to that shortly. On 21 November, having initially agreed to go back on the medication, there's a note that says, "Face to face on his own today", he sees RN Brooks.

> "Phone call to the home landline to advise parents Joel has a script for Abilify but has chosen not to have it filled at this time. Information given to his father, who became adamant that he did not want his son to go on medication as it will kill him. Father spoke that he himself had been traumatised by demons when awake and hears voices and is not on medication".

Professor Nordentoft, we've already spoken - this is no disrespect intended to Andrew Cauchi, Joel's father, who has had his own struggles with mental health, but in circumstances as a psychiatrist you want your patient, who is voluntary, to go back on to an antipsychotic, where his mother who reliably reports symptoms has reported satanic voices and her concerns, where a father then who has got mental health issues and psychosis says he doesn't want his son to go on medication, what options would be available to you?

WITNESS NORDENTOFT: Because it's a difficult, but I think that the mother has played an important role all the way through, so I would try to connect with her and, and - but of course it's difficult when the father is opposing and the, the son is more likely to not want to, to take medication. But, but I think that I would - I think still there is room for, for persuading and I, I think that should be tried out fully. But I understand it's a difficult situation.

DWYER: Would it suggest, if you want your patient to go back on medication, that there is a need for some sort of family education, of the father, of the mother, and of Joel, about the risks of not taking that medication?

LYNCH: Your Honour, I object to that. That omits the reference in the chronology to the clinic contacting the mother on 28 November to seek her input in relation to that.

HER HONOUR: Yes.

DWYER: I'll stick with the father. Given the father's reluctance for his son to go on medication, if the psychiatrist believes that that is necessary because of the return of psychotic symptoms, is there a need to educate the parent who is reluctant, Professor Nordentoft?

WITNESS NORDENTOFT: We, we actually touched upon that previously. I think it, it could be tried but I, I think the father has very firm views and that would be difficult to influence.

DWYER: On 28 November RN Brooks and Dr Boros-Lavack see Joel.

> "Mum was contacted by telephone, who told Joel to start Abilify for relapse prevention based on his early warning signs of relapse. Joel presented as well, feeling good with good sleep and no fatigue. He was going to Caloundra. He was not keen to start Abilify because of the dysphoric feelings on it in the past but was happy to start Rexulti if not going well mentally to prevent a relapse of schizophrenia."

Dr Heffernan, you can see there that Dr Boros-Lavack has an ongoing concern in relation to the risk of relapse. She hears what Joel says about his not being willing to start Abilify. She gives him - or the plan is to start Rexulti 1 milligrams in the morning and then 2 milligrams in the morning with a two-week trial plan, but to leave it to him to report symptoms. What do you think of that plan in response to the symptoms reported?

WITNESS HEFFERNAN: I think at this, at this stage, there's been quite a few red flags about a relapse of psychosis. And I think this is where a more assertive approach in terms of encouraging restarting medication needs to be considered. And I think, you know, it's very difficult when you have a voluntary patient, as, as most patients should be, to, to change a course that has been in play for some time. And unfortunately it does involve having some hard conversations and those conversations sometimes involve drawing a line in the sand about what you as a treating psychiatrist think is acceptable and what you think endangers that patient.

DWYER: Dr Nielssen, do you have any comment on that?

WITNESS NIELSSEN: I mean, I think the, the, the thing that we can't know is how much Mr Cauchi pushed back against the advice. And my guess, it's not just his father, it's he himself is quite determined. And perhaps the only thing missing really in, in Dr Boros-Lavack's notes perhaps might be a clearer, you know, account of his views and her attempts to persuade him, cause clearly she wanted him to go back on medication and, and he didn't want to.

DWYER: Given Joel's reluctance to go back on medication would you as a psychiatrist have to have a high index of suspicion that he might be masking symptoms at that stage?

WITNESS NIELSSEN: Most definitely, yeah. And, I mean, look, it's clear that he's relapsing but how urgent it is to treat it isn't quite as, quite as clear. And then suddenly we've got COVID and he's moved to Brisbane.

DWYER: I'll come to that shortly. Dr Harris and Dr Heffernan, you agree with

Dr Nielssen's perspective so far?

WITNESS HARRIS: Yes.

WITNESS HEFFERNAN: Yes.

DWYER: Professor Nordentoft, you wanted to add to that?

WITNESS NORDENTOFT: Yeah, and I think there might be on a systemic level also the question about compulsory treatment because, as I understand, there are differences between Denmark and Australia on that point. In Denmark we would be able to actually activate compulsory readmission if the flags were - if we had sufficient amount of red flags. I've been in that position myself where the patients have tapered and then symptoms started to re-emerge and I had to readmit him against his will.

DWYER: Is that in circumstances, Professor Nordentoft, where there is no direct evidence of a threat to either self-harm physically or harm somebody else physically?

WITNESS NORDENTOFT: Yeah, in that way the legislation is different. In Denmark, it's possible to compulsory admit a person who is having psychotic symptoms and where it's judged that these psychotic symptoms cannot be relieved unless a person is admitted to hospital and treated. So that's different on a systemic level.

DWYER: I'm conscious that we don't have you for much longer, Professor Nordentoft. So is it your view that that is a - I withdraw that. Is that the circumstance for all mental health disorders or just for a number that are in a particularly serious category?

WITNESS NORDENTOFT: It's not determined on a diagnosis. It's determined on the severity of symptoms. And the, the, the doctor who should make this declaration regarding the readmission or the admission should state that it is a severe psychotic condition that cannot be treated without admission. So that's, that's the legislation in Denmark.

DWYER: I'll come to you shortly, Professor Large, but Dr Harris, given your description of the risk of relapse for patients that have experienced psychosis, do you think that Australia should be considering legislation like that so that you don't have to wait till somebody is at serious risk to themselves or others if you determined that the psychotic symptoms are returning?

WITNESS HARRIS: I think that that's a very difficult balance between the rights of the individual and the need to, to, to institute involuntary care. And I, I think in this particular State, in this particular situation, I would personally be uncomfortable with bringing in a compulsory treatment that this - at this stage, which is - certainly looks like a relapse, but it would be, it would be a very early use of, of compulsory treatment, in my view, let alone practical issues of, of the hospital system just not being able to cope with that number of people.

DWYER: In response to what are the signs of relapse here, Dr Boros-Lavack arranges for him to be seen weekly for a period of time until around 8 January and then it goes back to monthly. Was there anything more assertive that could've been done within the private system?

WITNESS HARRIS: Within the private system, being seen on a weekly basis over Christmas is actually I think quite - by the nurse is quite an intense level of, of, of, of review. I think at this stage a referral to the public mental health system for some more assistance or review by that team would've been reasonable, however I'm not, I'm not familiar with the availability of those services in Toowoomba. So - but within setting of metropolitan New South Wales, then that would've been a reasonable thing for the private psychiatrist to do.

DWYER: Professor Large, I'm going to whizz forward to February and do a bullet point of the symptoms that emerged between November and February, but is there anything else you wanted to say in relation to what was evident as at 28 November?

WITNESS LARGE: Yes. I wouldn't have called for a family meeting. I think that would have very likely had the effect of creating a split within the family and increased emotion. I think it was quite reasonable for the doctors to communicate separately with mum and dad. So that's the first thing. I, I think it's - the, the, the, the main thing I'd have to say with respect to - this is going to sound tricky. What I'm going to say next is if he was having a relapse, and it looks like he might have, and you're in this situation, if you referred the patient to the - from the private sector, if you refer the patient back to the public sector you'll probably never see them again. That's been my experience as a private doctor. If you write a schedule or, or refer them, that's the end of your relationship with them. It's tricky.

DWYER: What you would do is to try maintain your therapeutic alliance with the patient?

WITNESS LARGE: Absolutely.

DWYER: And your alliance with mum who you know is really critical to him staying well, correct?

WITNESS LARGE: Yeah.

DWYER: You would also see signs in the notes of the clinic nurses trying to alleviate mum's concerns because of--

WITNESS LARGE: Yes.

DWYER: --the anxiety she has around her son--

WITNESS LARGE: Yep.

DWYER: --relapsing?

WITNESS LARGE: Yep. And one other comment, so words are starting to matter here and we don't have a private psychiatric system. We have a private psychiatric sector. We don't even really have a national, national public system. We have a State - a series of State systems but we don't have a private psychiatric system. That's a - there is no system. There's just individual practitioners. And here, what was unusual is there was something of a system in that there were nurses involved, but most private practitioners have no system at all.

DWYER: Professor Large, I want to just ask you about trying to work around the risk factor that Joel's father presented, accepting that he was a loving father and that Joel loved him very much and vice versa. Dr Boros-Lavack had decided that it was appropriate that he'd go on an antipsychotic medication. Information was given to his dad, who became adamant that he did not want his son to go on medication as it will kill him. Father spoke that he himself had been traumatised by demons when awake and hears voices and is not on medication. Isn't that a significant risk factor for Joel's relapse that, firstly, dad doesn't want him to go back on medication and, secondly, dad is himself somebody who is hearing voices?

WITNESS LARGE: That's been there all along throughout his whole course of his illness.

DWYER: But isn't it of significant risk at this stage where Joel is exhibiting symptoms which include hearing spirit voices or satanic voices?

WITNESS LARGE: It makes it less likely that he would take his medication, but patients don't always take their medication. They don't take their asthma inhalers. They don't take their antihypertensives. They don't adhere to treatment for cancer. They don't have a mastectomy when they need it. I mean, we, we, we don't have, we don't have acts for the compulsory treatment of other disorders and there's a threshold in the Mental Health Act.

DWYER: Yes, but Professor Large, the examples that you just gave of people not taking their medication might mean that it has an adverse impact on their own physical health, but what we know is a small number of people who experience psychosis go on to hurt other people, and it's catastrophic when they do.

WITNESS LARGE: That's also true--

DWYER: So it calls for a high index of suspicion, doesn't it?

WITNESS LARGE: That's also true of epilepsy. People don't take their anti-epileptics but there's no act compelling, compelling epileptics to take their anticonvulsants.

DWYER: But there's no connection between epilepsy and psychosis that goes on to result in homicides.

WITNESS LARGE: No, but people with epilepsy do harm other people during their seizures.

DWYER: Can I come then to the ongoing symptoms that are exhibited. On 4 December, Dr Boros-Lavack notes that she's got a message to ring Joel's mum. Joel left the family and is in Brisbane and mother feels he's confused. On 5 December the next day the nurse told Joel of concerns that his mother had and the psychiatrist and the mental health nurse, and encouraged him to take his medication. Joel was advised about compliance with his treatment and management plan and Joel remained steadfast that he believed his medication was good - sorry, that his mental health was good.

On 19 December, so some two weeks later, Joel reported that he had plans to relocate but doesn't see it as an issue because he could attend appointments in November. On 8 January Dr Boros-Lavack writes this, this is at page 21:

> "Seen with Brooksy. Totally well and doing well. Euthymic and apsychotic. Enjoyed a month holiday on his own in Brisbane and on Gold Coast. Has friends in Brisbane. Moving to Brisbane. Getting a room in a shared house and planning to find a job as an ESOL teacher in there. Parents are supportive. Plan. Congratulated for the progress. Continue no meds. Agree to monthly Skype appointments with me and monthly Skypes or phone calls with Brooksy."

That's 8 January. It's only a month and a half after mum has reported those extreme concerns including satanic notes, the funny gait, the confusion, and signs and symptoms have been noted by the nurses. Do you think that that note reflects a significant enough follow-up as at 8 January, Professor Large?

WITNESS LARGE: Well, I think that was her assessment and I've got no particular reason for thinking that that assessment was necessarily wrong. I mean, he may have been unwell but lots of medical practitioners were seeing him at that time and in the following year and not a single one of them really thought that he was psychotic.

DWYER: Professor Large, is there any evidence there on 8 January of any follow-up with mum given her significant concerns?

WITNESS LARGE: No, I don't think so.

DWYER: In those circumstances do you think that that is sufficient given that mum, who is a reliable historian, has reported those concerns on 20 November that have been taken so seriously?

WITNESS LARGE: Well, I think there are two ways of looking at it. Probably it would've been better if there had been some contact, but I mean mum was not

shy about contacting the Mi-Mind Centre if she had concerns either.

DWYER: But, Doctor, she'd expressed her concerns. The concerns had related in her being believed and a suggestion that he should take the antipsychotics that he wasn't taking. That appointment, can I tell you, was more than 75 minutes and they're the notes taken on 8 January with no indication that Joel's mother is contacted. Do you have any comment about that?

WITNESS LARGE: It's a short set of notes for a 75-minute consultation.

DWYER: Dr Nielssen?

WITNESS NIELSSEN: Yeah, I agree.

DWYER: What does that mean, it's a short set of notes? Does it give you any proper understanding of what his mental state examination was at that time?

WITNESS NIELSSEN: Well, it certainly sounded very glowing, really, her account. But you'd think that if, if she had spoken to him for that length of time, maybe some further signs of relapse might've been - become apparent, given that they didn't go away. I don't think those symptoms went away.

DWYER: Professor Nordentoft, this is 8 January. 12 November, I'll remind you, is the time when mum had written the email and her concerns have been reported. Do you have any comment about the consultation on 8 January where Dr Boros-Lavack noted that he was totally well and doing well but there's nothing to suggest a conversation with mum?

WITNESS NORDENTOFT: Of course it would better if the mum has been involved as well, but I, I see this as a sign of Joel being able to hide the - either not having symptoms at that day, or being able to hide it and present well. But it could have been revealed maybe if the mother has been involved.

DWYER: Is it common for there to be a level of masking for patients who are clever but have suffered from the condition that Joel did?

WITNESS NORDENTOFT: I think, yeah, we, we - also the, the casualty I was involved in, he was actually also able to mask his symptoms. So, so even though he was seen by a lot of professionals, they didn't understand really, or they were not able to reveal that he had such psychotic symptoms that he kept - held back. So I, I think it, it is a common thing that can happen.

DWYER: I've got two further issues, Professor Nordentoft, that I'm going to put to you before you have to leave us. On 14 February 2020, so that's just a month and a bit after that January consultation, there's been a couple of consultations with the nurses where he's noted to present as well, but:

> "On 14 February, Michele, his mother, called to express her concerns about Joel's functioning at home and his probable move to

> Brisbane. She said his self-care is poor, his father went around there to put the bins out and the place was a mess, there were dishes in the sink and mess everywhere. He appears more isolated and is irritable and is occasionally swearing."

In this circumstance where there's concerns about his self-care, he appears more isolated, he's now irritable and swearing, on the back of her concerns in November about his satanic preoccupation with notes and hearing voices, and in December that he was confused, do you have any view at that time about what was appropriate follow-up?

WITNESS NORDENTOFT: I think it is the same as in November. This report from the mother that everything messy is just underlining that he is deteriorating and that an assertive approach, and - but, but I think it must have been a real dilemma because she has tried to persuade him to take antipsychotic medication and he hasn't agreed. But I, I think it would really have been appropriate to, to try to persuade him again.

DWYER: Can I suggest to you that her evidence at this time is that she believed him to be well in spite of mum's concerns, by 14 February. So she sees him on Skype on 17 February, just three days later. There's no evidence of a discussion with his mother, and she says:

> "Seen on Skype, well-groomed, good hygiene with no tics, mentally good, no signs of psychiatric disorder. At his parents' house as his flat his under renovation. Sexually frustrated, can't hook up with girls at present".

So after 14 February when mum reveals her concerns about him more irritable, swearing, his poor self-care, Dr Boros-Lavack does not see him again in person because of the issues with COVID and his move. Given that he's about to move to Brisbane, and the stresses that might come with that, and the concerns expressed by his mother, was it reasonable to consider that he was well at that point in time, by 17 February, on the back of that Skype call?

WITNESS NORDENTOFT: I think it is a too superficial evaluation where it - the, the mother's concern is not taken into consideration to a sufficient degree. But could I say something?

DWYER: Please.

WITNESS NORDENTOFT: Before I leave, I would like to mention also the incident when he calls the police years after.

DWYER: Yes, I note that you'll have to leave us, so please, Professor Nordentoft, tell us what your opinion is of that occasion, that's 8 January 2023?

WITNESS NORDENTOFT: Yeah, the 8 January, and, and it's repeated in February. Both times he calls the police because his father has removed the

sharp knives that he has bought and eventually used in the, in the mass attack. And I think this explanation to the police and the mother's explanation to the police is very concerning. And, you know, in Denmark we have something called psychiatric emergency outreach where psychiatrists can be called by the police or by staff members in supported housing facilities, and also families. And I, I do - I actually had a duty in that service, and if, if I was on call and I was called to this situation, I would have organised a compulsory admission, because I think it was a clear message that he was psychotic, and also that he could be of potential danger to others.

Of course the knives were moved away, but just the fact that he had so many knives and, and his psychotic logic about them, that if he didn't have the knives he would go bankrupt and be homeless - become homeless. That's not a rational conclusion, that if you don't have a knife you become homeless or you go bankrupt. So I, I think there was a clear presentation that he was suffering from psychosis at that time, much clearer than what was - Dr Boros-Lavack was able to see. But at this point, it was pretty clear, and I think the police, maybe they didn't have anything else to do, but then you - I think you should consider on a systemic level, could the police have better access to mental health examinations, and, and - yeah.

DWYER: The reason for that is--

WITNESS NORDENTOFT: ..(not transcribable)..

DWYER: --you would accept, Professor Nordentoft, that a trained mental health professional is in a better position than a police officer to do that assessment at that stage?

WITNESS NORDENTOFT: Yeah, and also to draw conclusions, because I think they were concerned, the police officers, and they wrote note - notes about it, but they didn't take any further steps.

DWYER: Professor Nordentoft, can I stay with you for a moment for a final topic, which is in relation to discharge. I'll take the panel shortly after we've let you go to the letter that is written to a general practitioner, Dr Grundy, in relation to discharging Joel back into his care. That happens in March when Joel is no longer eligible for Medicare and his Skype call is cancelled--

HER HONOUR: That's March 2020 - because we've just been in January 2023.

DWYER: Sorry, going--

HER HONOUR: So we're just going back three years now, yes.

DWYER: Thank you. So just to remind you, his mother called on 14 February and reported her concerns in relation to his lack of self-care and she noted him to be aggressive, and she maintained her concerns about Joel's mental health decline. Dr Boros-Lavack saw him by Skype on 17 February, and she satisfied

herself that there was no longer a risk of concern in spite of what had been raised by mum. When he was handed back to Dr Grundy, the letter that was written to Dr Grundy presented that Joel was well, and she did not record in that letter any of the concerns that had been outlined by Joel's mother from October through to February. Do you have a comment on that?

WITNESS NORDENTOFT: Well, I think it would have been more appropriate to report in that letter to Dr Grundy that there were some concerns about risk of relapse that was voiced by the mother on several occasions. So I think also for Dr Grundy to be able to take some steps, and as I understand it, he also ceased to see Dr Grundy because he moved to Brisbane.

DWYER: That's right.

WITNESS NORDENTOFT: So maybe his possibility for doing something was also limited. But I think no matter whether Dr Grundy was going to continue to have care - have him under his care, I think it would be reasonable to write that there has been voiced concerns about risk of relapse.

DWYER: So whoever was going to monitor Joel, is it your view that he needed ongoing close monitoring by a psychiatrist after February 2020?

WITNESS NORDENTOFT: Yes. I, I think when you--

DWYER: And - please, you go.

WITNESS NORDENTOFT: Yeah, I think, I think the recommendations to monitor people after cessation of antipsychotic medication is to look after them for at least a year, and I think - I don't know if, if there are rules in different countries, but we have the clinic I've just talked about, they say 18 months at least.

DWYER: In this case Joel had been removed from his clozapine in June 2018 and from his Abilify in June 2019. Are you suggesting that at least from June 2019, he needed to be monitored for a year?

WITNESS NORDENTOFT: At least a year, yes.

DWYER: That was done, and Dr Boros-Lavack said that if she had - if Joel had not moved out of the area, she would have monitored him for the rest of his life. But given the potential relapse as reported by his mother, is it your view that he needed ongoing monitoring after March 2020 for the signs of relapse?

WITNESS NORDENTOFT: Yes, definitely.

DWYER: In Denmark would that happen, would there be ongoing monitoring by a psychiatrist or a GP?

WITNESS NORDENTOFT: I think actually it would vary. I think in some cases

it might actually be transferred to the GP, and that might be insufficient. I'm not going to pretend that it's - if Denmark is doing everything perfectly. But I think the, the recommendations are that it should be monitored for at least one year, and that would be by a psychiatrist. But it's not always practiced in Denmark either.

DWYER: When you say monitoring, given the symptoms reported by Joel's mother, what frequency would it be appropriate to monitor Joel?

WITNESS NORDENTOFT: At least monthly, but I, I think when there are these symptoms I would like to monitor it more closely. When I think of my own practice, I, I would be specifically aware, also when there are such red flags it might be very clear. But I don't think there are any firm recommendations regarding that, but I think that would be good practice.

DWYER: Professor Nordentoft, do we take it that it might be opportune to reflect on the circumstances of Joel's relapse around this time, and tighten up regulations, or specifically amend guidelines around weaning clients who have had psychosis off medication?

WITNESS NORDENTOFT: I think that would be a good conclusion. To, to have a recommendation that a patient should be monitored at least one year after cessation of the medication.

DWYER: What about this though: the patient should be monitored for a period of at least 12 months at particular interval levels once they exhibit potential signs of relapse into psychosis?

WITNESS NORDENTOFT: Actually I think they should be monitored also if they don't. But if they do present signs of possible relapse, it should be with shorter intervals. It should not be monthly, but with shorter intervals.

DWYER: I'll just pause there. Your Honour, Professor Nordentoft now has to catch a plane to receive the World Health Organisation Sasakawa Health Prize for Public Health, so I think she's leaving Denmark to go to Belgium to be awarded that prize, and that's why we're losing her after staying up all night.

HER HONOUR: Can I just say, Professor, thank you so much for making yourself available. It's been so valuable to have your input and congratulations on the award you're about to receive. Thank you very much.

WITNESS NORDENTOFT: Thank you, yeah, pleasure.

DWYER: I should say that I note that my learned friends didn't have an opportunity to ask Professor Nordentoft questions.

HER HONOUR: Yes.

DWYER: But she has offered to engage in the process of recommendations that might come as a result of the inquest, and I'm sure she'll make herself

available to answer any specific questions.

HER HONOUR: Thank you.

DWYER: In writing.

WITNESS NORDENTOFT WITHDREW

AUDIO VISUAL LINK TO DENMARK CONCLUDED AT 2.28PM

DWYER: Might I return then, panel members, to the issue of Joel's presentation as at February/March, and the options that were available to Dr Boros-Lavack at that time. I note that it was COVID and that Joel was moving town. Can I just put up on the screen the discharge letter that Dr Boros-Lavack wrote to Dr Grundy. She notes there:

> "Dear Richard, I've received advice from Medicare regarding the parameters of the Skype eligibility. Unfortunately Joel has moved recently and currently resides in an ineligible Skype area and as such I'm not longer able to offer Skype appointments. My receptionist has contacted Joel to advise of this change. Joel has indicated that he will be unable to attend face to face appointments with me due to the distance to travel from 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 need a new referral for that."

So the letter that has gone to Dr Grundy prior to this is 12 June 2019. It doesn't have to come up, but it appears at page 115. It says, "Mum agrees that since Clopine was stopped a year ago her son became totally well with remission of his psychosocial disability", and then on this letter there's no indication of any relapse for Joel. Dr Harris, given the mother's concerns and the previous letters, do you have a comment about that?

WITNESS HARRIS: Yes. I think that's one of the things that the mother and the father in fact were concerned about was the level of disorganisation when they saw Joel in his new flat in Brisbane. And that can be interpreted in, in two ways. It could be interpreted as a, as a relapse, or it could be the flat of a young man who has never looked after himself and has just moved out of home. So, in and, in and of itself, it's not - I know there, there is a logic here from the point of view of the - of his disorganisation and some of the other red flags. But some of the things that the mother and the father are contacting the Mi-Mind Centre about would be seen in, in most young men who move out of home for the first time. So, I think that that's, that's something which needs to be thought there to a certain extent.

DWYER: I don't want to interrupt you.

WITNESS HARRIS: Going back to the question that - if you could--

DWYER: Sure. I wasn't thinking more of the disorganised state of his flat. On 20 November, she reported that he had extreme OCD with showering, changes in behaviour, a lot of notes at home, that he had left notes that she'd read with content of satanic control, of religious themes. He had a funny gait.

WITNESS HARRIS: If we're - if we're going back to, to that. Yes, I certainly agreed that that is there a series of symptoms very suggestive of a relapse of his psychotic illness.

DWYER: From November through to February, the mother is reporting symptoms of concern. That's the most concerning entry.

WITNESS HARRIS: That's the most--

DWYER: But in February, she's expressing her concerns that he's more isolated, his self-care is poor, he's irritable and occasionally swearing. The last note that the GP has got in June 2019 is that mum agrees Clopine is stopped a year ago because her son had become totally well with a remission of psychosocial disability. Given that there had been very unusual concerns expressed by mum since that time, would you expect them to be passed onto the person who is taking over Joel at discharge?

WITNESS HARRIS: I think it would've been, it would've been better to describe some of those factors and some of the concerns about that he may be having a relapse, yes.

DWYER: Dr Nielssen?

WITNESS NIELSSEN: Well, again, you know, it wasn't, it wasn't a complete letter in terms of the, the recent events. And, and I do note it was written on 19 March, which is pretty much the week after complete lockdown. But, but yeah, just - it's, it's insufficient.

DWYER: Dr Heffernan, at this point, Joel is being discharged from her care after some eight and a half years. In circumstances where there's a significant risk of relapse as described by Dr Harris, and in circumstances where mum who is a reliable historian has reported that she's concerned he's hearing voices and there's satanic notes and there's poor self-care and there's confusion, if you're discharging to a GP who you've previously reported for many years that Joel is doing very well, and that mum is fully supportive of removing him from antipsychotics, would you expect to see that concern being reflected in the letter?

WITNESS HEFFERNAN: Yes, so I, I might just cover two things there. And I should say that I have a bit of experience with having to do this, because of the nuances of the Mental Health Act in, in Queensland as a treating psychiatrist in prison, I'm often treating people who stop their medication and are going to be

released into the community, and I need to refer them to somebody for ongoing follow-up, which is not, not a dissimilar situation.

So, the, the first - the first thing I'd, I'd say is I think it is very important to include the information about the mother's concerns about a possible relapse. So, I think that's just an important clinical piece of information. It might be that Dr Boros-Lavack follows that up with "But I have assessed him on a number of occasions and I didn't share these concerns, however this is important collateral information." So, I think that's number 1.

But I also think really importantly, number 2 would be "When I was last seeing Joel, my intent was that he continue antipsychotic medication". And I think perhaps a - an explanation just about how we got to a situation where he wasn't taking medication but what might be a - the, the psychiatrist's - a psychiatrist's recommendations from this situation going forward to help inform the GP about what might be a sensible plan going forward.

So, for example, including a sentence that, you know, "We discussed the risk and benefits of medication. Joel does not want to continue medication. I have had a discussion with him. My preference was that he should continue medication. I have encouraged him to take aripiprazole or brexpiprazole, you know, at this dose for these reasons". So I think that would be a, a, a second element that, that would be important in a - in a comprehensive discharge letter.

DWYER: On 14 February, his mother also reported to the Mi-Mind Centre, as recorded at page 19, that she was worried if Joel moved to Brisbane he may become homeless. Is that something that should be discussed with the person that you're handing over care to?

WITNESS HEFFERNAN: It, it is a very difficult situation to - because I think Dr Grundy is in Toowoomba and Joel has gone to Brisbane, and so really there is little that Dr Grundy can do, and it would be much more effective for a psychiatrist to refer to a psychiatrist in, in Brisbane or another general practitioner to ensure that continuity of care. I mean, I have a view about this which is that I think this is a situation that - where the public health system could've been utilised in terms of a referral.

DWYER: Let me come to that issue. Before I do, Professor Large, is there anything you wanted to say generally in relation to this period and the handover of information to the GP?

WITNESS LARGE: So, I've got no reason to think that in - on 17 February Dr Boros-Lavack didn't reach the conclusion that at that time had there been a relapse that that was - had resolved in some way. I don't - I also don't think that the specific information that mum was concerned about him would be likely to end up in a letter, given mum's telling the doctor, "Don't, don't tell him", because I think that would leak. It's a short discharge summary after a, a long period of care. We don't know whether - we don't really know what - I mean, you would've hoped that he would've come back to see Dr Boros-Lavack.

DWYER: Professor Large, the evidence of Dr Boros-Lavack, although it's disputed, is that she then phoned Dr Grundy. Dr Grundy says he doesn't recall receiving that, and if he had received that phone call he would've written a note. But putting that to one side, it's Dr Boros-Lavack's evidence that she phoned Dr Grundy but did not discuss with him any of the concerns that had been raised by mum.

Can I suggest to you - because this is an issue of significant concern to the families - that in circumstances where mum is regarded as a reliable historian, where Joel's been your patient for eight and half years, where these symptoms reported by mum are totally unusual compared to the eight and a half years that you've seen him, where the psychotic symptoms that he initially displayed in 2001 involved some satanic beliefs, if you're going to discharge him after eight and a half years without seeing him again face to face, you report to the person you're discharging him to what mum's concerns were?

WITNESS LARGE: So, I think communicating mum's concerns orally when you could have a conversation about the confidentiality issue is much easier to do than in a piece of - in, in a letter. It would be possible to put in a letter that there had been concerns about a relapse, independently of any view of mum; that would be possible to put that in a letter.

DWYER: But in any event, if it's her evidence that she didn't discuss it or raise it, then that's an oversight, isn't it?

WITNESS LARGE: Yes.

DWYER: I might just have that letter back again, if you don't mind? It's at page 113. You see there a referral back to the GP. But am I right to say, Professor Large, that that's not a mental state examination, that is, that there's nothing in there that actually gives you an idea of what Joel's mental state is at the time?

WITNESS LARGE: In the letter? No.

DWYER: Yes, and that there should've been?

WITNESS LARGE: Well, on 17 February - and I've got no reason to doubt this, except that it was by Skype - she thought his mental state was normal, and--

DWYER: But not even that is represented in that letter, is it?

WITNESS LARGE: Yeah - no, it's not.

DWYER: It should've been, or her views should've at least been expressed?

WITNESS LARGE: Well, you could've written a letter that said "Look there's a disparity between my assessment of the patient and the family's reporting."

DWYER: Dr Heffernan, can I come to you then to comment on that? Is that what should've happened, that there should've been an outline of what Dr Boros-Lavack thought the mental state of Joel was at that time, and the disparity as reported by members of his family?

WITNESS HEFFERNAN: The, the mental state is really the, the, the key to understanding a person's psychiatric condition. So, it's really important, if you're expecting somebody to take over care or manage the continuity of care, that you actually give them some indication of where that person is on the spectrum between well and severely unwell. So, irrespective of what you think about the, the collateral information or even whether you feel you should relay that in the letter, or by phone conversation or, or however, a, a standard piece of information from a psychiatrist to a general practitioner should contain information about that person's mental state and the symptoms that they're experiencing.

So, it might be something like "This individual currently is not experiencing any symptoms of psychosis, however has some ongoing psychosocial disability and negative symptoms", or it might be "This individual is currently quite unwell and" - but some indication, because otherwise it's a cold handover to the general practitioner who probably would expect more from a specialist.

DWYER: Yes, and the general practitioner's evidence is that he had not worked in mental health for many years and had no particular expertise and was of the view that Joel had been going well on the back of the letters that he had been sent. If you had any concerns about an ongoing risk of relapse, given the condition Joel had suffered from originally and that you'd taken him off that medication, should that be set out in a letter if you're referring it back so that you give the GP guidance about how often to see him and what sort of follow-up is required?

WITNESS HEFFERNAN: I think it should.

DWYER: Dr Harris?

WITNESS HARRIS: I think if this is a discharge letter, then it would've been reasonable to expect details such as a discharge diagnosis, which may have helped frame the issues that you're, you're putting forward there about whether he had schizophrenia in remission, in which case there wouldn't have been any ongoing concerns from the point of view of intensive follow-up, or whether there were other diagnoses in Dr Boros-Lavack's mind at that period, as well as details of any ongoing treatment. So, that would be standard in a discharge letter.

DWYER: I'm going to come to this issue that you are all passionate about, which is learning from this case and about how we might improve the system. Dr Nielssen has adverted to the difficulties that Dr Boros-Lavack had at that time in COVID, and that Joel was moving to an area in Brisbane and had not yet identified a GP at the time he moved. Dr Heffernan has raised his view

that it would be a better system to refer somebody back into the public system at this stage where they're moving out of area. Have I encapsulated that properly, Dr Heffernan?

WITNESS HEFFERNAN: Yeah, with the context that at that particular time in Brisbane the likelihood of getting a prompt psychiatric appointment in the private sector was going to be near on - well, very difficult.

DWYER: Dr Harris, do you have any comment on that, about whether or not there should be guidelines that assist a psychiatrist when a patient is moving out of area but has suffered from the type of severity of illness Joel had?

WITNESS HARRIS: I think it's reasonable, but the - one of the difficulties is - if - where would I refer that person on if they were in the private sector? So, for instance, I wouldn't know the names of any GPs in Brisbane if I had a patient moving from Sydney to Brisbane, as I not infrequently - it's not infrequently that that, that occurs. And, and it would usually be up to the, the patient to, to find, to establish a relationship with a GP in a near - in the area that they move to, and that that GP would then get back to, to me or my team and asking - and ask for information to be forwarded.

Similarly, it's, it's very difficult to identify psychiatrists who would be happy to take on someone with schizophrenia, who wouldn't be able to provide any sort of co-payment or additional payment to, to, to Medicare. So I - it is - in the way that our systems are configured, it is difficult other than to refer somebody to the public mental health team in - of the area in which the person is moving. And whether, whether Mr Cauchi would have been accepted as a referral at that stage is, is, is moot.

DWYER: Should there be guidelines then - given the risk of relapse for somebody who has experienced psychosis and been on clozapine, that you identify 90% will relapse within two years, and given particularly the symptoms that have been raised by mum, but even without them - should there be guidelines that say that if you've been the treating psychiatrist, you need to refer into a particular system, and then the other system needs to take that person?

WITNESS HARRIS: Into a system of ongoing care.

DWYER: Yes.

WITNESS HARRIS: That might be a general practitioner, because that might be the only person who's likely to take the, take the, the referral on.

DWYER: But when you're dealing with - let's stick with a patient who's on clozapine, or been on clozapine because they've suffered treatment-resistant schizophrenia. Should there be guidelines that say how that person should be discharged or handed over when they're moving out of area?

WITNESS HARRIS: For someone who's had a severe mental illness,

generally there should - it's reasonable to expect that some ongoing care be passed on. However, that has to be tempered with the, with the reality of what's likely to occur at the other end. Because there's nothing more frustrating than being told to contact a local mental health team and then not be accepted into care. And that's the - unfortunately the - a very likely outcome. And so, it's better to be accepted into care, ie, into a general, into a general practitioner, and then having had a discharge letter which says, "We would like you to continue to, to monitor for possible recurrence of psychosis".

DWYER: And gives the GP some guidance about how to do that?

WITNESS HARRIS: Yes, some - about how to do that.

DWYER: Dr Nielssen, are there currently good enough mechanisms for maintaining oversight of people with severe schizophrenia who have required involuntary admission at some stage who move out of area?

WITNESS NIELSSEN: Well, there are quite a number of community treatment orders floating around. We're - you know, Australia's the world champion in community treatment orders and it's a controlling kind of system. But of course, if you want to get off a community treatment order, the best thing to do is to, to move. Because it's very hard to transfer this, and no guarantee it would be taken up and that the treatment would be continued.

But I mean there's a, a chaotic movement of people with psychotic illness. McCafferty's up and down the east coat of Australia. People drop into the Matthew Talbot, they drop into the equivalent services in Brisbane and Melbourne. People come in and out of gaol, and we get very - you know, and there's no warning often when people come out of gaol, so they, they sort of arrive at you cold. You lose contact with people. You rely very much on, on patients to seek treatment. I mean it's kind of touching they do, in a way, because as we've heard, the medications are so unpalatable, and yet obviously the symptoms are so distressing or the, the lack of treatment is so distressing that people do seek treatment.

So, it's - you know, it's really, is the council of perfection to expect that we can keep track of all the people with schizophrenia floating around our community, and especially with the services that we have, because they, they are pretty threadbare, I've got to say.

DWYER: I'll come to the services that might otherwise pull people in, and homelessness services, but in relation to a patient in Joel's position who's been on clozapine and been weaned off clozapine, who's previously been treatment compliant, who moves out of area, is the best - is there a way of tightening guidelines to require the psychiatrist or advise the psychiatrist to do certain things at the point of discharge?

WITNESS NIELSSEN: No, I don't think we can exercise that kind of control over people actually. I mean really, it's sort of to have some kind of tracking system to, to--

DWYER: No, that's not it. But if at the time of discharge for somebody in Dr Boros-Lavack's position, would it be appropriate to review the guidelines to see if more assistance can be given to a doctor in that position about what she should set out at the time of discharge?

WITNESS NIELSSEN: Yes, I'm sorry. She should be - it should be clearly stated that there is a risk of relapse and that we are concerned that that risk is already there. She, she hasn't found that to be the case. The two psychiatrists he saw later didn't see it - him as being relapsing. But we also - it seems also pretty clear that he kept his symptoms to himself.

DWYER: Given the risk of relapse, even in the absence of overt symptoms that Dr Harris has reported, should those guidelines set out that for a period of X number of years, five years for example, there should be a further follow-up of patients?

WITNESS NIELSSEN: Yes, yes, I believe there should - we should make it quite clear that once stopping treatment, the risk of relapse is so high that we - you should keep in touch. Of course, yes. That is a--

HER HONOUR: But in reality, how would that happen if it's a voluntary patient?

WITNESS NIELSSEN: It has to be through the relationship between the patient and the doctor.

HER HONOUR: That's right.

WITNESS NIELSSEN: So, so, so it seems that Mr Cauchi and Dr Boros-Lavack had, had that kind of relationship.

HER HONOUR: They did.

WITNESS NIELSSEN: But it fell apart for a number of reasons.

HER HONOUR: And we know that Mr Cauchi saw two other - in fact three - psychiatrists in the intervening period after he was discharged from Dr Boros-Lavack. So even if he was referred to a psychiatrist, it would be difficult to make sure that he was still monitored for five years if he's a voluntary patient and chooses to not see the psychiatrist, or go off medication. And yet you were talking about, Professor Nielssen, about a community treatment order. That's very limited, isn't it, the people who'd be able to be put on a community treatment order where there's an element of involuntary demands made of them?

WITNESS NIELSSEN: Yes, well you'd normally have to have become mentally ill within the meaning of the Mental Health Act before an order like that could be applied for.

HER HONOUR: Do you think that would have applied in any way to Mr Cauchi?

WITNESS NIELSSEN: Well, not based on the assessments that were recorded, even though there was lots of warning signs that he probably was relapsing and was going to relapse. I'm just - putting myself in, in, for example, her shoes, I don't - and thinking of the New South Wales Act, of course - I don't think one could have made that application. It really relied on being able to persuade him to resume treatment, otherwise it's a, a watch and wait.

HER HONOUR: Yes. Sorry to interrupt.

DWYER: Not at all. In the report of Professor Nordentoft she refers to the absence of any signs in the notes that Dr Boros-Lavack was assertive enough in getting Joel back, in trying to get Joel back on his medication. And by 17 February, Dr Boros-Lavack says she has convinced herself that he's well again. Do you have any comment on that, Dr Nielssen?

WITNESS NIELSSEN: Yes. Well, firstly, it seems that she has taken him on face value and not adequately considered the risk, you know, that this was what was happening. That - and, and she hasn't spelt out that she has advised him to resume treatment in subsequent correspondence and, and entries. And I mean the, the, the assertiveness one assumes is in the course of her recording that she has attempted again and again to persuade him to resume a low dose of medication, because this is what's happening.

DWYER: Dr Heffernan?

WITNESS HEFFERNAN: I might just say, there's sort of three things I was going to say, and I'll be quite brief with them. The first is that when someone moves to an area in Brisbane, Queensland, there is an identified catchment for that area, as I'm sure there is in New South Wales. And there is a, a particular number that is well sort of published and known that can assist in a referral to the public mental health system. So that's about sort of knowing how to refer.

The second thing is that I have confidence that in Queensland at that time, having been a person that refers people like this almost on a daily basis in Queensland, that someone with treatment-resistant schizophrenia who is off all medication, who has had substantial contact with the public mental health service in the past, would be picked up by the public mental health system.

That would be seen in some ways bread and butter for the public mental health system, unfortunately, because the scarcity of resources, the focus really is often on major mental disorders such as schizophrenia. Someone with treatment-resistant schizophrenia, all the more reason to engage then in treatment. And somebody with treatment-resistant schizophrenia off medication would at least have the opportunity for assessment with some consideration of, well, what are the ongoing needs here.

And I, I feel confident that that would have happened in Queensland.

I understand from colleagues that that's not the case everywhere else, and I'm certainly not being parochial, I just - you know, we have all the problems everybody else does, but I'm just - you know, that, that is the type of situation that the public mental health system takes quite seriously in terms of providing assessment and follow-up.

The final thing I was going to say - the third thing - and so I was - I actually think that there's probably some interest in what Professor Nordentoft has said about deprescribing clinics and guidelines. There might be something to learn there. I have to say that's the first time I've heard of it today, but that does sound like an interesting way to enable a person to safely come off medication, and have a trial off medication, and having some guidelines around standards of practice for that would seem to be a sensible idea.

DWYER: Dr Harris, I could see you nodding at that point. Is that something that interests you?

WITNESS HARRIS: Yes, it is. There has been a number of trials looking at the best way to deprescribe, to take somebody off an antipsychotic medication, and really what those three studies have found is that people being taken off medication relapse in somewhat like the, the, the figures that I've, that I've suggested. However, the, the advantage of being in a particular clinic or having a particular protocol for that means that that risk of, of relapse is underlined as one of the purposes of the whole process. It's anticipated that may occur. And so the framing of the clinic is to identify and pick up relapse as, as early a stage as possible. So, it would be of advantage.

DWYER: Before I come to Professor Large about this, Dr Heffernan, given the Queensland experience, what would Dr Boros-Lavack have had to do to refer Joel into the public health system in Queensland?

WITNESS HEFFERNAN: So, there would be - there's several ways to access the system. So the first is, you know, it can be accessed by a phone call. There's a 1300MH call line that will be relevant to the catchment that you're referring into. You can call an acute care team directly in the, the relevant area. Or you could correspond in writing. So, there's a number of different ways that you can navigate that pathway. Now it's not always easy to navigate the mental health system, even for people who work in it, but a lot of efforts are made to ensure that, that there is a point of entry into a catchment area.

DWYER: It was Dr Boros-Lavack's evidence that she, I think I said earlier, she would have wanted to monitor Joel for the rest of his life. That was her plan before he moved to Brisbane. In circumstances where it's your belief that a patient should be monitored for the rest of their lives, it seems that it would be preferable, wouldn't it, for a doctor to be able to identify the service that you're discharging somebody to, rather than just leave that to a patient?

WITNESS HEFFERNAN: Well, absolutely. I think - well, it's a collaborative effort, you know. So, because you have to have the, the, the patient wanting to turn up. I mean I did notice that Joel did seek some psychiatric

appointments.

DWYER: Yes.

WITNESS HEFFERNAN: And so that's - you know, that indicates that he's - you know, he was at least open to that.

DWYER: Yes.

WITNESS HEFFERNAN: And so, we're having the psychiatrist and the individual, you know, working together on that entry I think is really important.

DWYER: In relation to - sorry, Professor Large, is there anything you wanted to add to the lessons about discharge or the ways in which we might improve that process?

WITNESS LARGE: I think it's very difficult to - for one private psychiatrist to refer to another private psychiatrist actually. Quite apart from the waiting list problem, there's a Medicare item number issue and the duration of the referral. So the usual pattern is to go back through the GP. And the collaboration between the - if you refer to another psychiatrist without a GP then that cuts the GP out of future care and actually - I mean, Joel's main risk was of premature death due to vascular disease. That's his main statistical risk of dying.

So post-discharge suicide is exceeded by vascular risk within a year of discharge and patients with schizophrenia have a premature mortality of about 20 years. So that's the main actual, like, mortal risk that he faced. So a GP needed to be involved. So the referral I think had to - whatever referral had to happen had to involve a GP.

The - most monitoring of patients with schizophrenia according to the SHIP study is in general practice. The monitoring of psychosis is within the core skills of a general practitioner. Psychosis is not a common disorder but it's common enough that every GP will have patients with schizophrenia.

Now, questions about the, the, the referral to the public system are I think complicated, but what I will say is functionally, the threshold for discharging a patient to case management back to their GP is extraordinarily high in New South Wales. So, taking their medication, putting one foot in front of another, having their symptoms sort of stabilised, that's the threshold. And the reason for that is there's - you know, the incidence of this sort of disorder is, you know, 20 per 100,000 per annum, so in a catchment area of 100,000 people you get a - of 500,000 people you get 100 new cases like this per year.

And we don't have, you know, an incrementally increasing case management service to cater with that, so people have to be discharged out of the other end. And when you think about who's discharged out of the other end you might think of all sorts of things, but a typical mental health, you know, public health mental patient has got some of the features of Joel but not many of

them, actually. So they're, they're - often they're not very bright. Often there's active substance use. There's usually direct contact between the patient and the criminal justice system or they've been in the emergency department with a suicide attempt.

They're the sort of typical patients that we look after in the public sector, and compared to them Joel would've been the sort of person that you would have referred back to a general practitioner and expect a general practitioner to manage. I know he was moving and that made things much more complicated, but that is the reality.

DWYER: Whoever was expected to manage Joel, whether it was a GP or a psychiatrist, needed to be fully apprised of the risk of relapse and recent symptoms. Do you agree with that?

WITNESS LARGE: Well, a, a GP should have some degree of presumed knowledge about schizophrenia and it's - and, I mean, I agree that the letter is slight, but, but we're not talking - we're talking - general practitioners have responsibility for mental health care. They are the main providers of mental health care in this country. Psychiatrists are bit players in this really in terms of, you know, the number of psychiatrists and the number of general practitioners. Mental health problems are primarily problems of general practice.

DWYER: Dr Nielssen, is it common for a general practitioner to manage a patient like Joel who had been diagnosed with treatment-resistant schizophrenia and had been on clozapine for 15 years or so and been weaned off?

WITNESS NIELSSEN: Yeah, quite common until they relapse, because that's what happens with this - these episodes of care where people are - with, you know, lifelong illnesses are referred back to GPs, is that they, they typically relapse. It's utterly self-defeating. I know it's an inevitable and a resource-related necessity but it's, but it's utterly self-defeating and it's one of the reasons our system is in the stress it's under, because we don't keep people well so they're always coming back in crisis. But anyhow, that's the way it is. But, but so in, in answer to your question directly, yes, it is common for, for GPs to, to manage people who've been discharged.

DWYER: Given the high risk of relapse that's been discussed today, it suggests, doesn't it, the need for continuity of care and to design systems that include keeping people in treatment of whatever form so they don't relapse?

WITNESS NIELSSEN: Yeah. That was, that was previously the model. When I started training that was the model. Community health centres would not discharge people with chronic schizophrenia. They'd keep treating them, on the whole. Until of course they ran away or stopped, cause quite, quite often patients refuse treatment.

DWYER: Professor Large is nodding at that. All of you throughout your long

careers will have seen a change in the mental health system then. Professor Nielssen, can you summarise that then? You referred to the Richmond Report. What was the change and what impact has it had on maintaining continuity of care for people with chronic schizophrenia?

WITNESS NIELSSEN: Well, my experience goes back to working as a psychiatric nurse in 1977, so - and that was - deinstitutionalisation had already occurred, actually. So it wasn't the Richmond Report that caused it. It was the response to, to the emptying of the asylums already at that time.

The - when I started training in, in the mid-late-80s, the community health centres were, you know, a pretty functional type of system. So you could, you could ring each centre directly. You didn't go through a 1800 number. I mean, I have the most dispiriting experiences of trying to refer people, you know, through, through that number. Their, their case managers were - you know, knew their patients pretty well, I think. There were psychiatrists at each of these community health centres. So in other words the psychiatrists who knew the patients were there. So really there has - it really has become much more chaotic.

The, the, the reasons it's happened are, are, are multiple. And, you know, doctor - Professor Large has alluded to just a growth in population really. The, the sort of services haven't really kept up with that. But, but they include the change to the Mental Health Act so that we don't respond to deterioration or anticipate deterioration. We have to wait in a way till - until people have deteriorated.

There's of course housing, because we did have a lot more housing options and, and the, the stress of housing, which has turned up in, in, in this case, means that people aren't in the stable situation where they can be easily treated. You can't treat someone who's not housed.

I mean, the, the change in patterns of substance use of course have made people a lot more acute, particularly methamphetamine but also potent cannabis, so that - and because it's almost ubiquitous, comorbid substance use, and of course we've had a little bit of that here. I feel that the recent substance use probably led to a much more acute situation.

DWYER: All of you are in agreement that when these terrible acts happened on 13 April 2024 Joel was experiencing a psychotic relapse of his chronic condition. Is that right, Dr Nielssen?

WITNESS NIELSSEN: In my - yeah, I think we've all agreed that in our, our consultation.

WITNESS HARRIS: Yes.

DWYER: Professor Large?

WITNESS LARGE: Look, I have two things to say. I don't think relapses are

always utterly self-defeating. They are self-defeating but actually that is the way that a lot of patients end up being adherent. They come off their medication, they get sick and they go, "Oh my God, I've been sick again twice now. I'm gonna take medication". Similarly with epilepsy. You know, one, one seizure doesn't necessarily convince a patient that they need to take antiepileptics. So relapses are not always utterly self-defeating.

Now, the way I would think about the events on - in April of last year are maybe slightly different. We - he didn't utter anything that I can make out of any significance during that episode. So we don't actually know. But one-third of people who run amok have got psychotic illness, so our starting point is about one-third. We know that he had schizophrenia, so we know the likelihood of him being psychotic is, is higher.

We know that he wasn't on treatment. That increases the probability somewhat. Although it is possible for people to - with schizophrenia to be involved in killings and mass killings even when they are treated. And finally, I mean, we know something about his demeanour on the day and he had cannabis on board. So that gets me well over the line for thinking - it gets me beyond the balance of probabilities. I think it's a near certainty that he was psychotic, but it's, it's a question of, of, of my belief. We believe, we believe that on the basis of this. We don't actually know.

DWYER: Can I add to what you've just said that we know that in 2001 police attended on his house because he was banging the doors and making bizarre noises. We know that he was pulled over three times for erratic driving in 2020 and 2021 without realising that he was driving erratically. We know that there was content on his phone which is bizarre and fanatical, dangerous in 2022 in terms of his obsessions with girls and women or with violence. We know that the violent content of his phone got worse, that is it had not been present prior to 2020 when he was medicated and it got worse.

We know that 8 January he was presenting in 2023 when the police went around that Professor Nordentoft said in Denmark he would've been detained, but certainly the police were concerned enough about his mental health to do a referral. We know that in December 2023 he recorded on his phone some bizarre videos that haven't been played in court which suggest that he is incoherent and muttering at something.

We know that throughout the day on 13 April when those terrible events were happening he said a few strange things like, "Catch me. Catch me", to somebody. Sorry, Liya Barko, one of the persons who was injured by Mr Cauchi, said that he said, "Catch you", as she was stabbed. Another victim said that she heard him say in a very monotone voice, "I have a knife. I have a knife. I have a knife", and his voice was very strange and didn't sound normal.

WITNESS LARGE: I read that. I'm not disputing that he was psychotic. I'm well - I knew all that other information. I think that in 2023 when seen by the police he was psychotic.

DWYER: I'll just pause you there then. That's your view, Dr Harris?

WITNESS HARRIS: On the, on the day of the events that--

DWYER: Yes, that he--

WITNESS HARRIS: --he was psychotic?

DWYER: --was clearly--

WITNESS HARRIS: Yes, I--

DWYER: --psychotic?

WITNESS HARRIS: I, I think he was most likely psychotic, yes.

DWYER: Dr Heffernan?

WITNESS HEFFERNAN: Yes, on the day of those tragic events I, I believe he was psychotic.

DWYER: Dr Nielssen, you don't have any doubt about that?

WITNESS NIELSSEN: No. I think it, it, it was an acute relapse that had been brewing and there was plenty of signs of it.

DWYER: I just want to come to the - I've got to sit down and let my colleagues ask you some questions but I just want to - we will have time to conference with you and Professor Nordentoft about improvements to our system to try and avoid this tragedy happening again, bearing in mind that although there are small numbers of persons with schizophrenia who are responsible for homicides, in the study that you and Professor Large did, Dr Nielssen, it pointed out that the homicides were persons who'd been found not guilty by reason of mental illness, about 80% or thereabouts had been committed by persons with a diagnosis of schizophrenia, is that right?

WITNESS NIELSSEN: Probably more, yes.

DWYER: In those circumstances with respect to the discharge, we can't conduct an inquiry into the whole mental system in this inquest but we are dealing with somebody with treatment-resistant schizophrenia who has committed these terrible acts in circumstances where he had tried very hard for a long time to be well and did not want to get sick and became sick. Is there room to amend the guidelines so that persons suffering from treatment-resistant schizophrenia can at least be retained or monitored more closely?

WITNESS NIELSSEN: Well, we could. I - if I - if you're starting with me, we could say that really if you've got treatment-resistant schizophrenia you should really advise people to stay on medication indefinitely. The, the odds of

relapse are so high. And then if the person elects to go off it then that they be monitored indefinitely because the, the, the - if, if possible. If such a relationship exists.

DWYER: I'll just pause there. Dr Heffernan, do you agree with Dr Nielssen there?

WITNESS HEFFERNAN: Yes, I agree with what he said and I've got other thoughts but we can leave that for--

DWYER: No, please share them. Do you mean in terms of generally in terms of discharge and follow-up?

WITNESS HEFFERNAN: Yes. I mean just, just--

DWYER: Please share.

WITNESS HEFFERNAN: --a couple of areas. I mean, you asked the question earlier about the deinstitutionalisation and, and I think what, what hasn't been said and is quite important is that the funding for community services never really followed to match that movement and that shift. And so that's really important. That's why you hear my colleagues and myself and other people from other jurisdictions, you know, a lot of the community services are drawn back into hospitals into acute care teams and in hospitals because they're simply overwhelmed inside the hospital. So, you know, I think that's, that's a real issue on a, on a day-to-day basis is the, the access to community mental health services.

And I think the other thing that I'll just mention quickly in case it doesn't come up, it is that, you know, we expect a lot from our police. And I think there is an opportunity to think about how does the mental health system work to support police and by corollary individuals in mental health crisis in the community in real time? How, how do we do that? And, and I have some thoughts about that, but I'll leave that for, for later.

DWYER: Dr Heffernan, that will be very valuable and we are going to hear next week too from the Police Commissioner in Queensland and some seniors in New South Wales, but I'll return to you on that issue in terms of the best models. Dr Harris, do you agree in relation to an amendment to the guidelines to provide some guidance with respect to treatment resistant schizophrenia, given the risk of relapse?

WITNESS HARRIS: I think it is reasonable to have guidelines about deprescribing and the periods of time for which people should be reviewed. I also think it's important to remember from the point of view of the people we are looking after with schizophrenia, that they, they do want to have a chance of being able to come off medication and it is reasonable, in, in the case of somebody like Mr Cauchi who was very well, he had recovered well overall that he be given a chance to come off medication. Because a small proportion of those people will be able to go on in life without medication.

And as Professor Large has said, sometimes it's only after a, a relapse that people realise that, that the medication really is useful and, and helpful. So it's not, in itself, always a disastrous thing that what's happening, as long as it's being monitored. So people - the expression in the consumer movement is that people have the, the - be given some dignity of choice and the ability to fail from the point of, of relapse. So I think that's, that's an important part of this.

DWYER: I think Dr Nielssen's suggestion was that the advice in a guideline would be that you really shouldn't come off medication rather than not telling you that you must not but that there are dangers associated with it, such that you should not.

WITNESS HARRIS: Yes.

DWYER: But if you are going to then there have to be ongoing monitoring, do you agree with that?

WITNESS HARRIS: Ongoing monitoring for, for a period of time and that is one of the moot points, because needing to turn up five years hence because - without any relapse or any illness would also be, firstly, something which I suspect wouldn't happen, but also would be an unfair imposition on somebody who had been well for a prolonged period of time.

DWYER: Currently the guidelines don't prescribe a period of time for somebody who has had treatment-resistant schizophrenia and should they?

WITNESS HARRIS: Yes, I think it is reasonable.

DWYER: Dr Large?

WITNESS LARGE: Well that's not quite true, actually. If you look at the guideline, which is a now extinct guideline, in figure 1, it goes down from clozapine back up to deprescribing and I think - and it makes a recommendation about how long people are monitored for. I can't remember precisely what the figure is, but it's quite short. But you can see that in the guideline, I just can't remember exactly. So there is a guideline--

DWYER: We weren't able to find somewhere that suggested that was the case with respect to chronic schizophrenia, that is treatment-resistant schizophrenia--

WITNESS LARGE: No, no, there is a line that goes from clozapine up to deprescribing in figure 1 in the, in the guidelines and you can't get clozapine unless someone thinks you are treatment-resistant. So there is a guideline around that. But I'd like to answer this just very slightly differently, and I don't mind changes in guidelines, but one in 500 people who present with schizophrenia present by way of a homicide. Olav and I worked that out a number of years ago. And there's a one year delay on average in getting into

treatment.

But only one in 10,000 people who have even had initial treatment for schizophrenia go on to kill someone. That's a homicide rate that's similar to the whole population of Louisiana, which is a State with the highest homicide rate. So a person in Louisiana is about as dangerous as a person with schizophrenia in Australia. It's a very dramatic thing. But the rate before you're treated is high and we don't want to do things that dissuade people from having treatment.

The second thing I wanted to say is about clozapine. So I just really want to make sure that - I mean, you said that I'd had something to do with the FDA. That's actually not true. I wrote two papers about the side-effects about the risks associated with clozapine and I'd been in a communication with a group called "The Angry Moms", who have in turn represented to the FDA and it had a big win with the FDA in the last year in the United States the requirement for close blood monitoring of clozapine has been dropped because it's pointless. And clozapine is the single antipsychotic that is most known to reduce violence.

At the moment there are - it's very complicated to be on clozapine and it's excessively complicated. And we've got two instances where we've got a disjunction between 1990 and now. One of those has been mentioned and that is with respect to, like, mental health resources we've kind of got 1990s tracks and 2024 trains in the mental health system. And with clozapine we have guidelines for clozapine that emerged when clozapine was reintroduced after being taken off the market because of agranulocytosis. But we now know this enormous amount more about it and we know there's absolutely no need for blood testing after six months. And that would allow more people to have clozapine. Clozapine is more - it's a better drug than other antipsychotics. People on clozapine, in average, live longer and they would be less dangerous.

DWYER: We'll come back to you about that out of session, but does anybody else in the panel want to comment on those changes that America has introduced to the use of or guidelines around clozapine and whether or not we should follow suit? Please?

WITNESS HARRIS: Yes, there is good evidence that we no longer need to prolong the, the monitoring for all - full blood counts for a point of view of agranulocytosis. However, continued close monitoring is needed for clozapine because of the range of other dangerous adverse effects that occur. However, that need for, for the monthly full blood count isn't there after, after a period of time.

DWYER: Are you able to guess what the estimate is or tell us what the estimate is, rather than guess? The appropriate estimate of interval of time that would take then for the monitoring. If it's not monthly, what is required?

WITNESS HARRIS: Clozapine has a wide range of adverse effects, as well as

- I think, we commented earlier, constipation is, is actually more dangerous to people in this country than agranulocytosis. Acute myocarditis, at the beginning of treatment is in many ways more dangerous than agranulocytosis. In the same way as the risk for, for those cardiac adverse effects is relatively time limited and loaded towards the, the front period of time of treatment. So agranulocytosis is, is - the risk of that is front loaded towards the opening months of treatment of clozapine. And then it is reduced to the same risk as most other antipsychotics in actual fact.

Monitoring for the, for the metabolic adverse effects of clozapine requires regular care which can also be provided in many ways by a general practitioner, because it's about weight, it's about exercise, it's about the, the assertive introduction of lipid lowering agents or metformin. That's, of course, best done with the psychiatrist also going in the same direction, but it's, it's a care which should be provided on a regular basis.

DWYER: Can I come off that now, because we'll come back to you about how that guideline might be written. Just a number of other topics before I sit down. One is in 2001, Professor Large, as you noted, Joel expressed an interest in getting a gun licence. In 2000 he'd actually threatened to shoot his father. In 2001 he also said something about wanting to be - this is while he was unwell - wanting to use a gun for some sporting interests. In 2021 he went to two psychiatrists to try and obtain a licence to use a weapon, he said because he wanted to go to the shooting range. Do you have a view as to whether or not somebody who has suffered from chronic schizophrenia with the sort of psychosis that was reported by Joel should have access to a gun licence, even for use at a shooting range?

WITNESS LARGE: Look, I just sort of concede a bit of bias here. I mean, I don't believe men should be allowed to have firearms. Men are much more dangerous than women, so I don't think men should have firearms. I definitely don't think males with schizophrenia should have firearms. I don't think women with schizophrenia should have firearms. And further to that, I don't think you should be able to get a pigging knife unless you've got - unless you're a hunter. So I'm all in favour of regulation of, of means of - of dangerous means. That was the message from Port Arthur. I think that Port Arthur really worked. So I've got a very straightforward opinion about that. But if you have schizophrenia, you shouldn't own a firearm.

DWYER: Professor Harris?

WITNESS HARRIS: I think that's reasonable.

DWYER: Dr Heffernan?

WITNESS HEFFERNAN: Well, there, there are guidelines about - around the assessment, firearm risk assessments and they're fairly comprehensive. Perhaps they could be easier to follow. And so I think, I think it's a complex question because as we've talked earlier there are some people who have schizophrenia who have recovery and do very well and there are others at the

other end of the spectrum who don't do very well. But as a general, general rule I would have a high degree of suspicion and concern that a firearms licence wasn't appropriate in, in - and required, you know, an assessment, a thorough assessment in terms of the appropriateness of that individual having a firearms licence.

DWYER: Do you think it's ever appropriate for someone who has had treatment-resistant schizophrenia to have access to a firearm? Will there be circumstances?

WITNESS HEFFERNAN: Apologies, I didn't hear the "treatment-resistant", in your question--

DWYER: No, that was my mistake.

WITNESS HEFFERNAN: No, I don't think so.

DWYER: Dr Nielssen?

WITNESS NIELSSEN: Yeah, treatment-resistant, I mean - and again, our - we've recently updated, I just saw the final version of our risk assessment document and all people who have had, you know, mental - you know, involuntary psychiatric treatment should perhaps have ongoing monitoring, if they're going to be - have these sort of licences.

DWYER: I'll come back to you about guidelines. Just two other topics. The first is in relation to the discharge issue. I raised with you - I won't go to the individual documents but if you can take it from me I raised with you the issue of the letter that went back to Dr Grundy. When Joel saw the two psychiatrists, the two psychiatrists received some - and in fact when he saw a GP neither the GP, Dr Ruge, who he saw most frequently, or the two psychiatrists who he saw for the gun licence on a one-off, understood the lengthy history that Joel had of mental health issues, which included over a decade on clozapine and the extent of the psychosis. Does that underscore the need for a summary, a discharge summary, if you're referring somebody out of your care who has had treatment-resistant schizophrenia, Professor Large?

WITNESS LARGE: Look, I think there is an issue with information sharing about serious mental illness that is not fully solved by My Health Record. And this sort of problem occurs within - you know, between area health services. It happens even more so interstate and it happens between the public and private sector. And I'm not sure exactly what the solution to that is but, you know, where a person - I mean, there's a balance between a person's right to privacy around their own medical information and other, other people's right to information. And, look, discharge summaries, there, there is an acceptable practice around discharge summaries. I mean, the thing I think here is - I keep thinking is probably no-one else was ever going to - in Toowoomba at least, no-one was really likely to treat Joel other than Dr Boros-Lavack, but he didn't go back to her and why was that?

DWYER: But when he went to Brisbane he did seek care, including from Dr Ruge and he disclosed at some point early on that he suffered from a mental illness, but he was not a reliable historian. He underplayed his mental illness and Dr Ruge was never given the background about a lengthy history on clozapine, being weaned off in the way that he was and mum's concerns raised afterwards. So it makes it difficult for a GP taking over care, do you agree with that?

WITNESS LARGE: Yes.

DWYER: I'll come to back to you about what some solutions might be in terms of better discharge policy. The final issue is to pick up what Dr Nielssen said. In his report at paragraph 149, to repeat those statistics, you say:

> "Another area in which the availability of services is declined is the shelter accommodation and medical care available to the homeless and mentally ill. In 1991 there were about 1,150 short stay beds in the four main inner city hostels where people who were homeless could also obtain meals, receive medical and psychiatric care and access a range of welfare services. Now there are less than 300 temporary beds and walk up psychiatric care is only readily available at the Matthew Talbot Hostel in Woolloomooloo and the Mission Australia Centre in Surry Hills."

So in spite of the population increase, those beds have drastically reduced from 1991 from 1,150 to 300 temporary beds. Habilis Housing is a registered charity that you have set up that attempts to address that gap. Could you tell her Honour what that is and what support there is currently from the government and what more is needed?

WITNESS NIELSSEN: Yes, well Habilis is - isn't unfortunately offering that kind of emergency shelter. It's really long term housing with clinical support on-site. And I think that's a correct model for care for the most severely mentally ill. And perhaps not Mr Cauchi necessarily, but, but he would certainly fit in quite well there I imagine, given the level of disability he had.

And, and again Haven in Victoria attempts to do this, and there's other services that attempt to do it but I think it's - the model envisaged by David Richmond in his report, and, and unfortunately it wasn't introduced. It was introduced in Italy where there's 30,000 similar beds which would translate to 4,000 in New South Wales. I estimate we need about a thousand of these kind of beds. And at the moment we've got about a thousand people with schizophrenia in prison.

So, so that's - in terms of it would - I think it'd be very helpful to open some, some shelter - more shelter type beds for people so they don't have to sleep in the open, because it's really a place - it's a hopeless situation in terms of having ongoing care if you're sleeping rough, you know.

DWYER: So is there a need for more of the short-term services, those short

stay beds as well as the Habilis type of accommodation?

WITNESS NIELSSEN: Yes, yeah. I mean the idea of the short stay really, or the idea of the Matthew Talbot, and it's actually very effective in it, they, they've got a caseworker there who from day 1, "Where are you moving to next? What's your longer term housing solution going to be?" I mean, the Housing Department are terrific to us, but as mentioned, the people with mental illness don't last in public housing estates, and that's why they need Habilis with, with supported housing. So given the type of disability you have with chronic forms of schizophrenia, you've just got to have supports on site.

DWYER: So you estimate we need about a thousand of those beds in New South Wales. How many are there with Habilis?

WITNESS NIELSSEN: Well there's 20 of us. There's - Haven has funding to open another 50 or so I believe. They've broken ground in the Central Coast. I mean there's other models. I mean most people who have schizophrenia are cared for by their families, but it's, it's that small group of revolving between hospital, between prison, between the homeless sector, and boarding houses untreated that, that will need these 1,000 beds.

HER HONOUR: Sorry, just to be clear, we've only got 70 in New South Wales?

WITNESS NIELSSEN: We've only got plans for 70.

HER HONOUR: Plans for 70?

WITNESS NIELSSEN: Mm-hmm.

HER HONOUR: And we need a thousand?

WITNESS NIELSSEN: Yes.

HER HONOUR: The cost of this compared to the cost of someone going to prison or beds in emergency services, emergency departments, how does - you've done some sums on that I take it?

WITNESS NIELSSEN: The, the cost, it's about a tenth. So in other words, it could be $10, say, for every dollar spent, and I base that on, on the cost of, you know $1,200 for a psychiatric hospital bed, $300 for a prison bed, you get a lot of them, $2,000 for a general hospital bed, so the first six people who came to us had generated costs of $1.5 million in the previous year, and the cost of caring for them would be less than a tenth of that.

DWYER: I'll leave it there for my colleagues, thank you your Honour.

HER HONOUR: Ms Chrysanthou.

CHRYSANTHOU: Thank you Professors. My name is Sue Chrysanthou and I

appear for the families of Ashlee Good, Dawn Singleton and Jade Young. On their behalf I'd like to thank you for your very professional and careful attention to these matters and the evidence you've given. I just want to clarify a matter that arose in the evidence of the treating psychiatrist last week, and I think you've been given a summary of that evidence.

Dr Boros-Lavack told us last week that she initially diagnosed Mr Cauchi with chronic treatment-resistant paranoid and disorganised schizophrenia. And she then gave evidence that she changed her diagnosis after receiving the discharge summary from the public health team, and she said she revised her diagnosis to that of first episode treatment-resistant schizophrenia, which remitted on clozapine. And she went on to say the first episode lasted for a long period of time until 2008.

You've all given evidence today that you agree that Mr Cauchi had chronic schizophrenia. Can you please help us understand, if there is an explanation, first of all whether there's some difference in those two diagnoses that the treating psychiatrist told us about last week, and if so what they are?

WITNESS HARRIS: I'm willing to, to address that. So when people are initially admitted to a psychiatric unit for the first time, they not uncommonly are given a diagnosis of a first episode psychosis because of some of the uncertainties about diagnosis which require a period of time to - for the diagnosis to be clarified, and for the full treatment to be defined. Professor Large spoke about that initially in that sometimes there's some uncertainty about whether somebody might have a psychotic mood disorder or a psychotic disorder such as schizophrenia.

That initial uncertainty is usually - and certainly Mr Cauchi's case resolved over the opening six months of treatment in which the absence of significant mood symptoms such as a manic episode I suppose, or a very severe depression in an elderly person. The range of symptoms that the person displays and the functional impairment that the person has would suggest that the diagnosis of schizophrenia is the appropriate one.

Chronicity, the diagnosis of a chronic schizophrenia suggests that the symptoms have gone on for at least two years without a remission of those symptoms giving - and the, the treatment resistance part of it, the diagnosis, is really a reflection of the criteria for starting clozapine. So has the person responded to one of two different antipsychotics initially given? If not, they're designated as having treatment resistance, and they're eligible for the initiation of clozapine under present Australian rules.

So Mr Cauchi had an unusual illness in that he didn't remit from his initial illness for the first couple of years, and so although in theory he - well, he can be described as having a first episode schizophrenia, that there was no real cessation of his symptoms. He didn't go into remission from the period of time when he was, first arrived in Toowoomba Base Hospital to around - well really to about 2011, 2012. However, he had chronic schizophrenia over that period of time because of the duration of his symptoms.

CHRYSANTHOU: Does the fact that Dr Boros-Lavack told us last week that she changed her diagnosis make sense to you in those circumstances?

WITNESS HARRIS: Not, not really. But, but I mean I don't think it has - the treatment remains the same. He was started on, on clozapine because of this lack of response to the olanzapine and the risperidone, and that was used as the treating agent throughout this period of time.

CHRYSANTHOU: Does anyone else want to make any comment about that?

WITNESS HEFFERNAN: I might make a comment. So, so - and I'll probably be repeating some of what Professor Harris has said, so one of the specifiers is about treatment, the treatment things, that's treatment-resistant, and that's all about clozapine. And then the other specifiers are time specifiers, so they're kind of in the same category. So first episode, and chronic, are time specifiers. The DSM-5 hasn't helped us in, in the way it defines these things, because it does - it's a little bit open to interpretation. But what the DSM-5 says is that the first, the first episode, the way I interpret it and the way it's written is that it's the first manifestation of the disorder meeting the defining diagnostic symptoms and time criterion.

So in other words, one interpretation, and I think probably a commonly used interpretation, is that first presentation to hospital Mr Cauchi was identified with the symptoms that met the diagnosis of schizophrenia and he was identified with the time criteria this has been going on for six months. That's his first episode. Whatever happens after that, we move on, and if he continues to have symptoms, there is no criteria defined in the DSM-5 for chronic - I think there was in the DSM-IV, and I believe it was a two year specifier. And I think if you asked most clinicians and showed them the chronology of Mr Cauchi's illness they would say that was his first episode in 2001, and he's got chronic schizophrenia.

CHRYSANTHOU: So do you disagree with Dr Boros-Lavack's subsequent varied diagnosis as she explained it last week?

WITNESS HEFFERNAN: I wouldn’t describe it as a first episode schizophrenia.

CHRYSANTHOU: Thank you. Does anyone else want to add anything to that?

WITNESS NIELSSEN: No, it's chronic schizophrenia.

CHRYSANTHOU: Professor Large?

WITNESS LARGE: It's chronic schizophrenia. Of course you can present with chronic schizophrenia and first episode schizophrenia and that's not even rare. So people who've been untreated for a long time in the community present with all the problems of chronicity and being treatment naïve. Look, it's a tricky

one because he wasn't really in a second episode. But he certainly didn't have first episode psychosis.

CHRYSANTHOU: Thank you. I just want to ask you some questions about the transfer of care. It seems that here you had a patient who was very carefully cared for, for about 19 years, both in the public system and the private system, and then just completely fell off the radar and that there was no passing of the baton, so to speak, in relation to his care. There were attempts for subsequent doctors to pick up his care and those attempts were unsuccessful in the sense that he either didn't exhibit any psychosis or he was masking his psychosis.

One of those examples was quite early on and it was in November 2020, so only six months or so after he was discharged back into the care of his GP. And if I could just get up onto the screen briefly tab 806. These are the medical records of Cornwall Street Medical Centre, and this was a request for the transfer of Mr Cauchi's medical records, and if I could just go to page 16 of that document. I'm not sure if you've seen these before. While that's coming up, what we had was a request on 26 November 2020 signed by Mr Cauchi, and it was called a request for medical records transfer to a new psychiatrist, Dr Sarkar, and you'll see there's actually two versions of the document.

There's one which, the first page, if we just scroll down briefly please, which ticks all clinical records, and then there's a second version which ticks multiple boxes. If we just scroll down to the next page. And that was signed by Mr Cauchi. And the response by the Mi-Mind Centre to that request was to provide for GP letters. So the letters that were provided in response to that request for transfer of medical records was the letter to Dr Grundy, if we go down to page 18, and you've seen these before. I'll just quickly show you which ones they were.

The letter to Dr Grundy of 12 June 2019 where Dr Boros-Lavack reported that Joel had come off his medication and was about to come off his secondary antipsychotic, and how well he was doing. Then the next letter over the page was on 3 May 2018 on page 19. Again, reporting how well he was doing. And another one on 5 April 2018 on page 20. And then a fourth letter from 6 March 2012 which was the initial consultation letter with Dr Boros-Lavack. So those were the only records provided to the new treating psychiatrist in November 2020 and you'll note, for example, it doesn't include that final discharge letter. What are your opinions on the sufficiency of that amount of information from the Mi-Mind Centre to the new treating psychiatrist who had asked for a transfer of the medical file, having regard to the history of Joel's treatment from 2001 to 2020? Whichever one of you wishes to start?

WITNESS NIELSSEN: Was there a phone call as well?

CHRYSANTHOU: No.

WITNESS NIELSSEN: Or there was a - there was one--

CHRYSANTHOU: There's no suggested evidence of a phone call between these two particular doctors.

WITNESS NIELSSEN: Of course it's not the complete medical record and it's - but it's as someone who often asks for medical records for reports and so forth, it's pretty typical of what one would get, especially if you're dealing with the, the, the administrator rather than the doctor directly.

CHRYSANTHOU: It's not typical, but isn't it hopeless? Isn't it quite hopeless that over 19 years of medical care a new psychiatrist is asking for medical information of a person who has had a very complicated and longstanding treatment regime, that this is all that they were given?

WITNESS NIELSSEN: Yes, it's adequate, but I'm, I'm guessing that they also had the discharge summary or they would've had the discharge summary from the public sector, and that really should've been included as well as, as you say, the last - the last letter for, for better or worse.

WITNESS HEFFERNAN: Well I think as a psychiatrist who has worked in private practice and somebody that does receive patients and the medical records that come with them, I would've found that quite confusing, because I, I wouldn't have been able to equate the first discharge, the, the, the, the last letter in the sequence which was, you know, paranoid schizophrenia, disorganised and clozapine with like where are we now, someone that's not on any medication, and I - and I, I think probably I would've initiated a phone call to Dr Boros-Lavack and said "I just want to talk to you about this just so I can piece it all together".

So, I guess the corollary of that is that it would be expected that you would get more information and at least a summary of how all of this information connects. Because the last thing also that you want as a - as a private psychiatrist is to have to piece together chronologically lots of different pieces of information. So, you know, there's, there's a problem in receiving too much information, there's also a problem in not, not receiving enough. And in some ways, the best thing really is to get a summary and a phone call.

CHRYSANTHOU: Would you consider, when you're considering recommendations in this case, some sort of recommendation when it comes to keeping and transferring medical records for people in the position of Mr Cauchi? Is that something that you could please think about? Because here it appears to be something where this particular patient fell through the cracks of the medical system. Professor Harris, did you have anything to add to that?

WITNESS HARRIS: It's an inadequate amount of information. There's no doubt about that. I think sometimes the most useful pieces of information are details of admission and discharge, as they tend - they reflect the symptoms at the nadir, the, the, the worst time for, for the individual, and give a sense of what symptoms were there and help makes sense from the point of view of diagnosis, as well as that course of, of the, the, the person's illness with the

letters that Dr Boros-Lavack wrote assiduously to the GP. So, that would've given quite a, a long - there would've been a lot of letters, that it would've given - they would've been available and would've given a good idea about the, the course of the - of Mr Cauchi's illness.

CHRYSANTHOU: In February 2020, we know that Dr Boros-Lavack formed the view, and it's recorded in her notes that you have, that Joel needed to be monitored every month, once a month by her and an additional time by a psychiatric nurse. So, twice a month. Once by a psychiatric nurse, once by a psychiatrist. We also know she did not pass that on to any person, any subsequent doctor. She did not tell Dr Grundy that that was her view a month later. And she did not pass on that information to any subsequent medical practitioner that asked for information about Joel Cauchi. Do you consider that to be an adequate level of transfer of information from one practitioner to another?

WITNESS HARRIS: So the - there seems to be a, a difference in that suggestion of frequency of observation and her, her own perhaps rose-tinted view about Mr Cauchi's clinical state when she discharged him from her own care, in which she clearly was reasonably optimistic about him, and, and as she had looked after him over a period of time when his medication had been successfully reduced and, and ceased. So, as we've discussed, certainly I would suggest continued review by, by a medical - by a, a medical practitioner. Hopefully, psychiatrically trained, but a general practitioner would've been a reasonable - a reasonable person to do that, if Mr Cauchi had remained well.

CHRYSANTHOU: I think my question is, the fact that Dr Boros-Lavack formed the view that he needed that review. There's no doubt in her medical records in February that she considered it necessary that he continue that monthly review, and the fact is she didn't tell anyone that. She didn't tell his GP when she discharged him, and she didn't tell any subsequent medical practitioner from 2020 to 2023 who sought his records. Do you consider that acceptable from a psychiatrist in private practice to not have passed on her view, as recorded in her own records, that he needed monthly monitoring?

WITNESS HARRIS: As we've already agreed with counsel, the discharge summary was, was brief and, and, and did fail to have a large amount of information that would've been reasonable to include in it.

CHRYSANTHOU: Professor Large, do you think it was acceptable that she told no-one her view?

WITNESS LARGE: So, look, correct me if I'm wrong, but I think it's my understanding of a request for the entire medical file is that it is just that. And I, I think there is - that's not well understood, and often as someone who frequently wants information about patients that get admitted to hospital, often enquiries about previous history don't produce enough information.

CHRYSANTHOU: But again, can you try and focus on my question?

WITNESS LARGE: Look, it's obviously a problem.

CHRYSANTHOU: It's a big problem, isn't it, that she told no-one that he needed monthly review in her opinion, being his psychiatrist for eight years?

WITNESS LARGE: I, I think he needed to be reviewed regularly.

CHRYSANTHOU: And she needed to tell someone that, didn't she, when she was discharging him from her care?

WITNESS LARGE: It would've been much better had she done so.

CHRYSANTHOU: Does anyone else have anything to add to that?

WITNESS HEFFERNAN: I think the other thing is that sometimes you, you will encounter a patient for the first time and you will have a poor amount of information, but that patient can give you a really clear and concise history and so it becomes a moot point. You've gathered a really excellent history yourself from the patient. But looking at Dr Boros-Lavack's record, she noted that there was - that, that he had an unclear plan, poor eye contact, used stock words, and she formed the view that he may have an autism spectrum problem. And so I guess it just highlights the point that this was a situation where someone perhaps wasn't in a position to communicate a good history, and it emphasises the importance of that handover of information.

CHRYSANTHOU: That's not unusual, is it, that a person who has schizophrenia is not capable themselves of properly communicating their history? That happens, doesn't it?

WITNESS HEFFERNAN: Of course, it does happen.

CHRYSANTHOU: No further questions.

HER HONOUR: Thank you. Mr Fernandez?

FERNANDEZ: Other than thanking the experts, including Professor Nordentoft for their careful evidence, this is on behalf of the family of Faraz Tahir, I have no questions.

HER HONOUR: Dr Freckelton?

FRECKELTON: Not only does it happen commonly, I suggest, that people with schizophrenia have difficulty in communicating an accurate history of their mental illness, but there can be reasons why they may not wish to do so, is that right?

WITNESS HARRIS: Yes.

WITNESS HEFFERNAN: Yes.

WITNESS NIELSSEN: Yes.

FRECKELTON: That may particularly be the case if their earnest wish is to be free of antipsychotic treatment that has side effects that they do not like.

WITNESS LARGE: Yes.

WITNESS HEFFERNAN: Yes.

FRECKELTON: Might that very well have been the situation with Joel Cauchi in relation to a succession of medical practitioners whom he encountered from 2020 to 2023?

WITNESS HARRIS: I think he actually wanted to have a gun, and so that he was interested in, in, in, in not conveying the full part of his history, primarily because of that.

FRECKELTON: Yes, but that's certainly the case in relation to two doctors whom he consulted for the purpose of trying to secure permission to be able to shoot a gun at a firing range. But it would seem that he was disinclined to communicate the full breadth of his history of mental illness to a whole series of medical practitioners during that period, is that right?

WITNESS LARGE: Yes.

WITNESS HEFFERNAN: Yes.

FRECKELTON: Dr Nielssen, do you agree?

WITNESS NIELSSEN: Yes, I do.

FRECKELTON: One of the distinctive characteristics of Joel Cauchi we seem to be able to divine from this sequence of interactions with persons in the period 2019 to 2023, was that he may've come over to them as a little odd or a little unusual, but no-one formed the view that he had such symptomatology of mental illness that he seemed to pose a serious risk to himself or others. How do you explain that in terms of the pathology that you have identified, his having chronic schizophrenia, and I think each one of you has agreed that he was in a process of relapse from 2019 onwards? Perhaps starting with you, Dr Nielssen?

WITNESS NIELSSEN: Well, all the alarming things that we've learnt about weren't available to anybody, and they were - you know, you don't know his internet searches until you get his phone later, and he had no criminal record. He, he - I mean he certainly seemed odd when he was - you know, having watched a number of interactions with the police recorded on bodycam, there's certainly signs of some kind of mental disorder, and, and plenty of laypeople that he came across were, were it seems in their statements aware that he was mentally ill. But there was no - there was - apart from his interest in weapons, there, there was no other really alarming behaviour in, in public

situations.

I think there was the one incident at the Toowoomba Fair where the police had become a little bit concerned. But when he was shaken out of his sleeping bag in New South Wales a couple of times, no immediate concerns of the police. They were aware of a history of mental illness on their little tablets, so--

FRECKELTON: He didn't seem to act in a threatening way toward anyone in the presence of police or medical practitioners?

WITNESS NIELSSEN: That's correct, yes. Well, not that we're aware of.

FRECKELTON: So, it was a situation that one of the reasons why coercive powers to take him for assessment or coercive powers to make him an involuntary patient didn't occur is that to this whole series of people who interacted with him during this four year period, he didn't appear to be posing a serious immediate threat to himself or to others.

WITNESS NIELSSEN: I mean the one - yes, I mean that, that - that's correct. The one exception I feel is the - is when the police were called to his family home, and - but that's again in 20/20 hindsight.

FRECKELTON: It is, isn't it? Because the police spent time with the mother and the father and with Joel, and they observed him to be calm, non-threatening, and of course the knives had been taken away from him, so they didn't feel an immediacy of threat to himself as a result of that presentation, although he was clearly unwell.

WITNESS NIELSSEN: I, I think it was a - it was a missed opportunity, and that it may've been because of the divided evidence gathering. You know, the, the, the policeman who seemed to be the senior officer spoke to Mr Cauchi. Whereas the policewoman got quite a good history of, you know, significant, significant alarm from the mother, but they didn't quite put it together properly. And, yeah, it's just a shame. That, that, that, that was a missed opportunity. But in all the - in, in, in all the other interactions there were no clear grounds for involuntary treatment under the Mental Health Act.

FRECKELTON: Would you concede that even with that episode there was some significant ambiguity in relation to any immediacy of threat to himself?

WITNESS NIELSSEN: Yes.

FRECKELTON: Dr Heffernan, do you agree?

WITNESS HEFFERNAN: I think I, I agree that there was a sequence of events that involved the contact with police and on each of those occasions each individually he presented as somewhat odd and he was pulled over for erratic driving, which, I, I mean, it might be common but three times in a, in a series of events. And so it just emphasises the importance of that information all being linked up. But I think the, the, the incident in 2023 highlights an issue

with the change in the Queensland Mental Health Act from the EEO to the EEA provisions.

FRECKELTON: Is this where the provision enabling a mandated detention and removal for assessment moved from the Mental Health to the Public Health Act? Is that right? And it continued to require an immediate and serious risk but it was changed from immediate and serious risk to self and others to immediate and serious risk to self, is that right?

WITNESS HEFFERNAN: Yes. So the - exactly that. And, and really, you know, that enabled a sort of a broader context of, of problems to be taken to emergency departments for involuntary assessment, but it did remove the criteria around risk of harm to others. And so it does highlight what does immediate risk of serious harm mean. And I think what most people think about when they think of immediate risk of harm to self, they're thinking about suicide.

FRECKELTON: That's the example actually given in the legislation, isn't it?

WITNESS HEFFERNAN: That's the example given in the legislation, absolutely, in the, in the explanatory notes. But in fact we have to think about risk, I think, in a much broader sense that risk of harm can also be risk of deterioration, mental deterioration, physical deterioration. You know, risk of reputational damage. Risk of - a risk from others. For example, risk of vulnerability, risk of stigmatisation. So risk is a, is, is a broad concept and, and, and I think one of the challenges in the EEA, and, and in this, this situation highlights it, is that there is perhaps an expectation upon police to be able to interpret what an immediate risk of serious harm means in order to activate an involuntary assessment. And that's a challenging process.

FRECKELTON: With no assistance from the words in the legislation?

WITNESS HEFFERNAN: With, yeah, with very limited assistance, yes, I would agree. And having said all of that I would say that if somebody has as collection of knives, but not just any knives, knives that are used as weapons and are sold online as weapons, and there is information suggesting that they're very unwell, as Mr Cauchi's mother communicated to police, you put those two things together and you might come up with the conclusion that this person's going to present a serious risk of harm to themselves.

FRECKELTON: If you factor into the metrics the fact that the knives had been removed so there was no immediate risk of his accessing them and using them, is that part of an appropriate reasoning process for ambulance or police officers to utilise?

WITNESS HEFFERNAN: I think what it's highlighting is the importance of a collaborative approach to mental health, helping police in that immediate setting about how to interpret that situation.

FRECKELTON: I want to ask you a little bit more about that and I apologise to

the two other members of the panel to whom I'll return, but since Dr Heffernan has raised that, there are a number of things which have been taking place in Queensland to assist police to make better informed decisions in these ambiguous and complex situations, is that right?

WITNESS HEFFERNAN: Yes.

FRECKELTON: The liaison service to which you made reference in answer to questions from my learned friend earlier in the day is one of those and an important component, is it not?

WITNESS HEFFERNAN: Yes.

FRECKELTON: That this enables police to make contact with a clinician to get advice and assistance to understand how they might best respond?

WITNESS HEFFERNAN: Yes. So it, it enables the real-time exchange of information. Unfortunately at that time the service was relatively small and, and perhaps there wasn't the understanding across the breadth of the service that, that it even existed, and so there's an opportunity to increase that knowledge and awareness, and alongside with that I guess training around what--

FRECKELTON: What it can offer?

WITNESS HEFFERNAN: --immediate risk of self-harm might be beyond the explanatory notes.

FRECKELTON: Let's go back to the risk issue and then go back to what you've just raised in relation to the service. The issue of risk can be multifaceted, as you've said. It can be risk as is identified on the legislation that a person is going to harm themselves, potentially lethally, but it could be that they're going to engage in other forms of disinhibited behaviour which might harm their reputation or their finances or other aspects of their lives, correct?

WITNESS HEFFERNAN: Yes.

FRECKELTON: Or it might be that they may engage in provocative or dangerous behaviour putting themselves at risk by reason of speeding in a manic way on the roads or by being provocative toward others and thereby harming them and themselves?

WITNESS HEFFERNAN: Yes.

FRECKELTON: So risk on its own is a complex concept but if anything the clarification in the legislation as it is right now, the example in the legislation confuses the situation by focusing paramedics and police minds upon risk of suicide rather than other relevant aspects of risk?

WITNESS HEFFERNAN: I, I think that's, that's fair.

FRECKELTON: In those circumstances are you aware that Queensland is the only jurisdiction in Australia so far as we know which has changed its criteria for detention and transport for assessment from serious and immediate risk, slightly different words are used in different places, to self and others to only to self? So Queensland's now on its own in this regard.

WITNESS HEFFERNAN: I was, I was aware of the change, and significant change. I wasn't aware that Queensland was the only jurisdiction.

FRECKELTON: The position for Queensland Police Service is that it would be advantageous in terms of assisting police members and also ambulance officers to revert to the previous situation and clarify immediacy, risk and extend it to risk to others. Would you be supportive of a legislative change along those lines?

WITNESS HEFFERNAN: The, the, the balance is that it - and, and the, for want of a better word, risk of such an expansion is that the provisions of the Public Health Act that have enabled broader spectrum of problems, so illness, disability, injury, intoxication, to be involuntarily transported when combined with risk of harm to others may actually cast the net--

FRECKELTON: Too wide a net?

WITNESS HEFFERNAN: --too wide. So that's the balance.

FRECKELTON: There's an obvious answer, isn't there? That is that you walk this provision back into the Mental Health Act and make this aspect of it mental health specific so that the message is clear to paramedics and to police officers that if there is the requisite risk to self and others as a result of mental illness, it should be exercised so that the person is taken and assessed by a qualified mental health practitioner?

WITNESS HEFFERNAN: That might be a good question for the Executive Director of Mental Health, Alcohol and Other Drugs, who I believe is now a party to the, to the proceedings.

FRECKELTON: Without making things difficult for you, can you see some merit in there being a mental health specific provision in relation to the exercise of coercive powers for assessment for police and ambulance officers?

WITNESS HEFFERNAN: Yeah, that, that--

FRECKELTON: To avoid the net widening that you referred to?

WITNESS HEFFERNAN: Yeah, so that, that, that might be a solution to the net widening. It was what was in the previous Mental Health Act, and I understand that there was a lot of consideration by police that that actually put them in, in a challenging position with respect to having to make decisions that

were, you know, somewhat approximating clinical decisions. So that was - I think that was some of the feedback which perhaps was influential in the change.

FRECKELTON: At any rate, the discussion that you and I are having highlights the complexity of the evaluative process - I'm deliberately staying away from "diagnostic" - but the evaluative process required of both ambulance officers and police faced with a complex situation of a person on a particular occasion in determining whether the requisite risk is made out to exercise coercive powers?

WITNESS HEFFERNAN: It's a very difficult evaluative process and it's a very important and significant power to take someone involuntarily to a hospital. And it's - you know, this is why I think it's, it's so important that if we can have all the relevant thinking and information available in that particular interaction in real time, that will really assist those decisions, and that's why I think there's a responsibility for the mental health services, where it's feasibly possible, to actually contribute, either through information sharing or the provision of advice in relation to those decisions.

FRECKELTON: You've made reference to the significance of the power to exercise force to take someone for an assessment they may not want. First of all, it takes clinical and police time and quite a bit of it on any given occasion to take someone to a hospital for them to be assessed, correct?

WITNESS HEFFERNAN: Mm.

FRECKELTON: Secondly, it does constitute the use of force against someone who may well have a mental illness, and that itself can have some countertherapeutic consequences in terms of their response to police and ambulance officers in the future, correct?

WITNESS HEFFERNAN: Mm-hmm.

FRECKELTON: And it may also lay a problematic basis for the construction of a positive therapeutic relationship between the individual and clinicians if they've been taken to clinicians through the use of force?

WITNESS HEFFERNAN: Yes, that's true. It does happen not infrequently, but yes that's true.

FRECKELTON: What it highlights is that it shouldn't be done more often than is absolutely necessary?

WITNESS HEFFERNAN: Absolutely.

FRECKELTON: Going back to the points that you've made about the liaison service. What you've identified is that it has the potential to enhance decision making by police in particular by getting input from experts in the area about questions to ask and issues to identify and people to speak to, things to think

through, correct?

WITNESS HEFFERNAN: Well, well, perhaps a little bit narrower. More through the provision of information.

FRECKELTON: That's going to enable them perhaps to ask some questions of family members or the individual concerned--

WITNESS HEFFERNAN: Well--

FRECKELTON: --in a better way?

WITNESS HEFFERNAN: --the, the, the next iteration is going to enable an - some assessment in real time by a clinician through digital technology.

FRECKELTON: That's the future, in short?

WITNESS HEFFERNAN: Yes, the near future.

FRECKELTON: So, again, you would be supportive of both that technological development and implementation, and also sufficient funding to allow it to be utilised at whatever times it's necessary, including in the middle of the night?

WITNESS HEFFERNAN: Yes, well there is funding that has been allocated to this through the Better Care Together funding, which is a Queensland Mental Health Services plan.

FRECKELTON: Yes.

WITNESS HEFFERNAN: And it does enable - I'm just thinking about the middle of the night - it does enable that to occur until close to midnight.

FRECKELTON: The trouble is, things happen also at 1 and 2 in the morning, don't they?

WITNESS HEFFERNAN: They do. They do indeed.

FRECKELTON: Would you be supportive in principle of an extension of funding to enable that kind of assessment to be undertaken at all hours as necessary?

WITNESS HEFFERNAN: I would.

FRECKELTON: We've spoken so far about this Queensland initiative that you're very positive about. Has that been replicated elsewhere in Australia, to your knowledge?

WITNESS HEFFERNAN: Not, not in the exact form. And some of it is yet to be rolled out, although it has funding to be rolled out. So not in the exact form. Some of the limitations are funding in other jurisdictions, the database being a

statewide database, in jurisdictions, the relationship between police and mental health. But my very preliminary and superficial assessment of this is that it is possible to roll this out on a national scale.

FRECKELTON: Just thinking in terms of recommendations, given that her Honour is focusing on some issues in Queensland and others in New South Wales, but would you commend to her consideration of the advantages of such a system for New South Wales as well?

WITNESS HEFFERNAN: I absolutely would, your Honour, yes.

FRECKELTON: Thank you. You've made reference also to the co-responder model in Queensland, which is also a Queensland specific initiative that doesn't have direct parallels elsewhere, is that right?

WITNESS HEFFERNAN: Similar things in Victoria.

FRECKELTON: Victoria, yes.

WITNESS HEFFERNAN: And possibly even in New South Wales. But what we're talking about there is different. So, it's clinicians embedded in a call centre. A co-responder model is generally thought of as a clinician and, we'll use police as the example, a clinician and a police officer in a car together going to a particular incident.

FRECKELTON: A scene.

WITNESS HEFFERNAN: Yes.

FRECKELTON: There are two models currently operating in Queensland as I understand it - and please correct me to her Honour if I get it wrong - but the first model is to have a clinician attending through the ambulance to join police who are already at the scene?

WITNESS HEFFERNAN: Mm-hmm.

FRECKELTON: And the other model, which is smaller, but being introduced in some parts of Queensland, is to have a clinician with a police officer attending first at a scene, is that right?

WITNESS HEFFERNAN: Yes. So, the two models; an ambulance co-responder and a police co-responder.

FRECKELTON: A police co-responder?

WITNESS HEFFERNAN: Yes.

FRECKELTON: They're both comparatively recent, but is it right that initial evaluations of them have identified real advantages in this health incorporated response by police or others?

WITNESS HEFFERNAN: So, their advantages are that they're a high-quality service. So, you've got--

FRECKELTON: High quality in terms of the involvement of clinicians?

WITNESS HEFFERNAN: You've got a clinician there on site.

FRECKELTON: Yes.

WITNESS HEFFERNAN: So that's high quality. The disadvantages are that they're a low volume service and geographically limited, because you just physically can't get to many jobs in a shift. So that's the big limitation.

And so where I would argue that these systems work best is when you've got acute care teams working with co-responder teams, working with the collaboration of police and mental health embedded in general services throughout, you know, mental health services, and a police communications mental health liaison service. So, each has its own component and works together synergistically.

FRECKELTON: Is that the aspiration for Queensland, further development of each one of these three components?

WITNESS HEFFERNAN: Well, it's my aspiration for Queensland. I'm not sure I could--

FRECKELTON: I'm not asking you to speak on behalf of others, but do you think it would be constructive for there to be further development and evaluation of each one of these three components of the semi-pilot response being trialled in Queensland at the moment?

WITNESS HEFFERNAN: Yes, I think it would. I mean we know all these things are expensive. They have, you know, some risks associated with them. But, you know, they look like they have the opportunities to bring that collaboration between mental health and police into, or mental health and ambulance, into a real time situation. Which has always been the sort of rate limiting step in the past. And what we know is that, you know, police in any jurisdiction, no matter which one you go to, we heard in the Royal Commission in Victoria, and we heard similar things in Queensland from the police in Queensland, that the volume of mental health related calls and mental health related incidents has increased dramatically.

FRECKELTON: The big advantage of each one of these three components is that it intrudes a clinician response into what otherwise might be a policing dominated first response?

WITNESS HEFFERNAN: Yes, digitally, verbally, or in person, depending on what's required and how things should be deployed at particular times. And obviously that's an enhancement to the existing acute care systems, which are

under a lot of stress.

FRECKELTON: Have you encountered instances yourself in respect of each one of these components, the three that are in operation already, of which have been constructive in terms of enabling an informed and effective intervention?

WITNESS HEFFERNAN: Very much so. I work in this service most days. I do the clinical reviews every Tuesday, and we see a lot of ability to bridge that gap of communication between what's happening on the street and what the mental health service needs to know.

FRECKELTON: Yes.

WITNESS HEFFERNAN: So that's one really important--

FRECKELTON: It facilitates information sharing?

WITNESS HEFFERNAN: Yes.

FRECKELTON: Apart from other things. So once again focusing on the reality that her Honour is sitting in New South Wales - and I'm going to ask your colleagues if they have any comments on what we've discussed - is consideration of introduction of comparable processes something that you would commend for New South Wales, and other jurisdictions for that matter?

WITNESS HEFFERNAN: Well, yes. Yes, it is. And further to that, we've actually had New South Wales Police and New South Wales mental health clinicians come and visit the service to, you know, take back some ideas about the feasibility of that.

FRECKELTON: Thank you, Dr Heffernan. Could I just give your colleagues on the panel an opportunity to make any comments in respect of the various matters discussed between myself and Dr Heffernan, starting with you, Dr Nielssen.

WITNESS NIELSSEN: I think they were Queensland matters.

FRECKELTON: Yes.

WITNESS NIELSSEN: Look, I didn’t follow the details of what's being proposed, so--

FRECKELTON: But a clinician-led co-response, do you see merit in that in terms of situations of crisis which require attendance of police?

WITNESS NIELSSEN: Well, generally it sounds like a good idea.

FRECKELTON: Dr Large?

WITNESS LARGE: Look I've forgotten the initial question, the truth be known. But in New York if you ring 911, there's a triage right at the very beginning, and if there's no firearm involved, then the New York fire brigade, which is the most trusted organisation rather than the police, go out with mental health workers. Because whenever you send police into a situation of there being someone who is mentally ill, there is a possibility that the poor patient will be shot. So, I am in favour of there being actually kind of less involvement of police in acute mental health situations in the community.

FRECKELTON: Or at least more of a clinician involvement?

WITNESS LARGE: At least more of a clinician involvement, yes.

FRECKELTON: Thank you. And Dr Harris?

WITNESS HARRIS: So, this has been looked at in a number of different ways over the last few decades, and initially community mental health teams would visit with police on home visits when issues were arising. That fell away with the loss of cover by community mental health teams overall and the communities, just with the defunding and the loss of services.

FRECKELTON: Roughly when?

WITNESS HARRIS: Through the past two decades steadily that has occurred. The police after a number of very public issues in New South Wales adopted a US model of mental health intervention teams and instituted quite significant efforts to retrain - well, to train police staff. That was with the assistance, that program was set up with the Schizophrenia Fellowship of New South Wales at the time. And that was a reasonable program but suffered from a redeployment of priorities and services within the police force.

And so although there is regular training for all police officers - and I'd have to say in a lot of cases the police do a very reasonable job - that has not got the same, I'm not sure about the priority of that within the New South Wales Police at the moment, but it would not be as good as a joint response as suggested by Professor Heffernan.

I am aware in New South Wales there has been a number of pilots looking at combined police, ambulance and other services coming together to go out and intervene together, however that has had the problems of being a pilot and not being rolled into a service. And so, these pilots do exist in New South Wales, but they haven’t eventuated in a proper service, as far as I'm aware.

FRECKELTON: Worth being looked at further?

WITNESS HARRIS: Yes.

FRECKELTON: What do you make of the proposal in Queensland, which sounds imminent, of the introduction of a virtual clinician into these scenarios through digital technology?

WITNESS HARRIS: I think it's a pragmatic solution towards a difficult problem of trying to provide mental health expertise across the whole breadth of New South Wales, and even within metropolitan areas, given the volume of calls that are coming in for the police to handle. So, I think it's a reasonable thing.

I have one, another comment in regards to some of your original questions which centred on the 2023 response by police. Of course, those police did channel their concerns through to a liaison officer.

FRECKELTON: They did.

WITNESS HARRIS: And unfortunately, that liaison officer wasn't able to--

FRECKELTON: There was an administrative error.

WITNESS HARRIS: --follow through. And that's a great pity.

FRECKELTON: But a positive thing for them to have attempted to identify a mental health issue which required follow up.

WITNESS HARRIS: Indeed. So even the existence of that regular contact with, between police and mental health services is a good thing and needs to be more, those channels need to be built up, and the capacity issues which I understand was one of the issues that particular time need to be addressed. So I think that would have been - although I don't think within New South Wales - I'm certainly not an expert on Queensland law - Mr Cauchi would have been detainable under the Mental Health Act at that time, it would easily have been a point in time in which contact between mental health services and Mr Cauchi could have been initiated.

FRECKELTON: Yes.

WITNESS HARRIS: And that may have been helpful at that time. The other period of time which possibly some interventions could have arisen was when he requested to look at the girls' sporting carnivals, which he did on two occasions; a training session and a swimming carnival. Which was certainly an unusual request by a member of the general public and something which did raise concerns, and they were communicated. And that dissipated into nothing at that stage. Again, not something which would have come under the Mental Health Act, but something which may have initiated a query back to Mr Cauchi.

FRECKELTON: Thank you very much, that's helpful. Thank you, your Honour.

HER HONOUR: Thank you, Dr Freckelton. Ms Robb.

ROBB: Thank you, your Honour. Thank you everyone. For the purposes of

these questions, I'm acting for the Chief Psychiatrist of Queensland. Dr Heffernan, to start with, you were asked some questions about Emergency Examination Authorities and the criteria that apply. And I note that you've set out some information about EEAs in your report.

WITNESS HEFFERNAN: Yes.

ROBB: You've helpfully at point 7 divided up the different options that might have been available to different parties who had contact with Mr Cauchi in the years prior, including police and family. I'll note that to start with. An Emergency Examination Authority, as I understand it, is a pathway to an examination?

WITNESS HEFFERNAN: Yes.

ROBB: Which is then a pathway to potentially obtaining a recommendation for assessment?

WITNESS HEFFERNAN: Yeah, so the, the Emergency Examination Authority is all about assessment.

ROBB: Yes.

WITNESS HEFFERNAN: Yes and then that assessment might occur in the emergency department. It usually occurs in the emergency department. It might make its way to mental health and it might lead to a, a recommendation and involuntary treatment.

ROBB: To be clear, when you say it's all about assessment, really isn't an Emergency Examination Authority what it authorises is the transport of a person to a place where they may be assessed?

WITNESS HEFFERNAN: Yes, yes.

ROBB: The question of whether or not they're assessed falls to the health practitioner at the other end, not to the person transporting them?

WITNESS HEFFERNAN: That's right, yes.

ROBB: So the making of an Emergency Examination Authority does not mean that a person gets assessed?

WITNESS HEFFERNAN: Yes, of course. Yeah, that's an important point, yes.

ROBB: And it certainly doesn't mean that a recommendation is made that they are placed on involuntary treatment, for instance? It doesn't flow?

WITNESS HEFFERNAN: It doesn't necessary follow.

ROBB: You gave some evidence about the move of the provision that enables

first responders to make emergency examination orders to the Public Health Act and that that included removing the focus solely on mental illness to including a mental disturbance regardless of the provenance of that disturbance?

WITNESS HEFFERNAN: Yes. So - yeah, I believe the wording is the result of a major disturbance in the person's mental capacity.

ROBB: Which is then, just to read the rest of that sentence--

WITNESS HEFFERNAN: "Whether caused by illness, disability, injury, intoxication or another reason".

ROBB: Thank you, that's what I was looking for. Thank you very much. So in those circumstances what that empowers is someone who isn't a clinician to go, this person doesn't seem very well, I'm not really sure why but my index of suspicion is sufficiently raised. I'm very concerned they're going to harm themselves, perhaps because they're literally just about to, there might be obvious indicia of that, and I can intervene. I have power to intervene. Whereas otherwise I would have no power to intervene.

WITNESS HEFFERNAN: Yes.

ROBB: So it enables, in effect, a first responder to do something that would otherwise be an assault?

WITNESS HEFFERNAN: Yes, I think that makes sense.

ROBB: And that's to prevent, we would understand, one would infer, an emergency, a terrible thing happening then and there?

WITNESS HEFFERNAN: Yes, so the, the wording is "immediate risk of serious harm", yeah.

ROBB: And I think Professor Harris has given some evidence that it may have been unlikely that at that particular point in time - one of the points of time we're talking about is January 2023, that on examination - and I'll use some local terminology here that will get it fleshed out elsewhere, and I'm in Queensland in that sense, he may not have met the treatment criteria as at January 2023?

WITNESS HEFFERNAN: Yes, so that - I, I think that's the part that's sort of open to interpretation really depending on what you think the risk is and what the serious harm is--

ROBB: Sure, but just to be clear here, we're now talking about the treatment criteria under the Mental Health Act which is quite separate to the criterion for being able to exercise the powers under an Emergency Examination Authority under the Public Health Act.

WITNESS HEFFERNAN: Okay, sorry, I thought you were talking about the Emergency Examination Authority. No, the, the treatment criteria of the Mental Health Act are imminent risk to self and others.

ROBB: And is there another criterion in the treatment criteria in addition to risk of harm, as in physical harm to self or others?

WITNESS HEFFERNAN: Serious deterioration, you know, physical and mental deterioration.

ROBB: Right, so it still needs to be serious and proximate, but it includes a deterioration of mental or physical health, not just the risk of harm to another person and not just the risk of harm to self?

WITNESS HEFFERNAN: And of course there's capacity criteria and mental illness criteria, but--

ROBB: Of course, but if we're just focusing on the so-called harm criterion, the fact is under the treatment criteria, there are two pathways to satisfying that. One is that the person in front of you poses an immediate risk to themselves or others, either of self-harm or of physical injury. And the other that is that without imminent treatment or treatment of their illness their condition will deteriorate either physically or mentally.

WITNESS HEFFERNAN: Yes.

ROBB: Is the latter of those easier to satisfy in most cases where you have someone who you think is frankly psychotic in front of you?

WITNESS HEFFERNAN: It depends where you practice. In my practice I see a lot of risk of harm to self and others, but yes, in general terms that would be - you know, if you've got someone that is psychotic, and you think they're on a pathway to evolving further and further and deeper and deeper psychosis, then you're able to satisfy that criteria.

ROBB: I'm jumping back a few steps again, but you talked again about some changes in the legislation in Queensland that happened with the introduction of the Mental Health Act 2016. Is it fair to say, whilst we're talking now about the ability to force someone into a position where they're examined, there is a focus under the Act of course in encouraging people to attend voluntarily.

WITNESS HEFFERNAN: Well, I, I - you know, I think that was one of the principles of the, the new Mental Health Act that really focused on, you know, the rights of the individual, engagement with families, alternatives to using involuntary treatment.

ROBB: And would you understand that that would be consistent with another piece of legislation in Queensland, which is the Human Rights Act 2019?

WITNESS HEFFERNAN: Yes.

ROBB: To come back to point 7 and the subpoints in your statement, one of the options that you highlight as being available to family is the ability to apply for an examination authority.

WITNESS HEFFERNAN: Yes.

ROBB: We heard from Inspector Quinlan the other day that that's an option that's also available to Queensland Police. In fact it's available to anyone - it's available obviously to clinicians but to persons who have relevant information that would enable that such an application be brought.

WITNESS HEFFERNAN: Yes.

ROBB: Given Mr Cauchi's presentation in January 2023, what do you say about the pathway towards trying to obtain an examination of Mr Cauchi that may be obtained by way of an examination authority as opposed to an Emergency Examination Authority and the assessments - or circumstances that they're likely to lead to, bearing in mind that the Emergency Examination Authority would have been exercised in the early evening in Toowoomba, which I assume would have resulted in Mr Cauchi being taken to the emergency department of the Toowoomba Base Hospital.

My assumption is that's the option that were available, I'm sure we'll may hear more from Dr Reilly about that later, but do you see there being any particular efficacy either way? Are you likely to get more traction under an examination authority than in an Emergency Examination Authority, presenting as Mr Cauchi did at that time?

WITNESS HEFFERNAN: So an examination authority, you know, in my experience - firstly, it enables an involuntary assessment. It needs to be made by the Mental Health Review Tribunal. All efforts to undertake voluntary treatment need to be precede it, of course. But it does enable, for example, a concerned family or a concerned significant other to apply after trying to voluntarily access services to have an individual - if it's supported by the Mental Health Review Tribunal to have an involuntary assessment. That could have been used in this circumstance.

We have to consider the issues of - that have come up earlier today about preservation of relationships and particularly, you know, critical and important relationships and how they - that might impact on that decision making. And also that somebody has had 19 years of - or at least 18 years of voluntary treatment, you know, these things, I think, should be weighed into the equation, so it's not a simple equation to, you know, justify an examination authority. But if a person appears to be psychotic and the descriptions of Mrs Cauchi, you know, were really quite significant and quite concerning, then that would seem to be reasonable grounds to at least make an application.

ROBB: And do you understand, I think you made the point that an examination authority is something that's made by the Mental Health Review

Tribunal. The Emergency Examination Authority by contrast is something that's made, in effect, by a first responder in an emergency.

WITNESS HEFFERNAN: Yes.

ROBB: Is it your understanding, or section 504 of the Mental Health Act 2016 specifies that the risk or harm criteria that apply to an examination authority are both, and this is at 504(2)(d), is or may be an imminent risk because of the person's mental illness of serious harm to the person or someone else or the person suffering serious mental or physical deterioration. So you note that, that's - so the second criteria is picked up there.

WITNESS HEFFERNAN: Yes.

ROBB: Do you think it's appropriate that that criterion with respect to the risk of the suffering of a serious mental or physical deterioration is limited, in its application, to the MHRT, as opposed to first responders. That was very poorly put and I'll try again. I'll withdraw the question.

Something has been made of the distinction. The fact that an EEA cannot be made in circumstances where - can only be made in the circumstances where there's a perception of a serious harm to the person, to the subject, to the person of self-harm, do you think this criterion in relation to the suffering of serious mental or physical deterioration is something that's best placed in this clinical framework rather than in a first responder framework?

WITNESS HEFFERNAN: Well, when we talk about first responders we're talking about quite different things. So ambulance are health trained and police are not health trained. And so I think that's an important distinction. And so I, I think what you're talking is having an ability to understand what might lead to a physical or mental deterioration. And that's not necessarily a simple thing. And it's particularly not simple when it comes to issues of psychosis.

So, for example, you know, I see - have seen on many occasions police being called somewhere because someone believes a person is in the roof or is moving objects around the house, and it would seem evidently apparent to a clinician that that person is psychotic. But because they don't say I'm, you know, wanting to harm myself or I'm wanting to harm others, then it's difficult for the police to enact an EEA. So with appropriate training and with a collaboration between - and I'm using police here specifically because ambulance have health training.

ROBB: Yes.

WITNESS HEFFERNAN: With a collaboration between health and mental health and that criteria would be of more benefit.

ROBB: Yes.

DWYER: Your - sorry.

ROBB: No, please.

DWYER: I was just raising to find out timings. I think Mr Lynch has about ten minutes and Ms Mathur has about ten minutes, so--

HER HONOUR: Yes. Are you nearly--

ROBB: I am.

HER HONOUR: Thanks very much, Ms Robb. Would you like a short break?

ROBB: Could I just finish, your Honour?

HER HONOUR: Yes.

ROBB: I'm very nearly finished. Really just the short point is then to establish that there's more than pathway to obtaining an assessment for an unwell person who is otherwise not connected in with the mental health system in Queensland?

WITNESS HEFFERNAN: Yes, I agree with that.

ROBB: Thank you.

HER HONOUR: A five minute break?

WITNESS HEFFERNAN: I'm okay, thanks your Honour.

WITNESS NIELSSEN: I'm, I'm okay.

HER HONOUR: We'll continue then. Mr Wilson?

WILSON: I've got no questions, thank you.

HER HONOUR: Mr Lynch.

LYNCH: Professors, based on the Mi-Mind Centre assessments that were conducted by the several psychiatrists at the Mi-Mind Centre, including Dr Boros-Lavack and the credentialled mental health nurses, Mr Cauchi in their assessments never reached the threshold for involuntary treatment under the legislation then applicable, do you agree with that?

WITNESS HEFFERNAN: Yes.

WITNESS NIELSSEN: Yes.

WITNESS HARRIS: In, in as much as I understand the Queensland--

LYNCH: Yes, Professor Large, do you agree with that?

WITNESS LARGE: I don't think he got near it.

LYNCH: In those circumstances, there was no option open to those treating Joel Cauchi between 2012 and 2020 when the treatment ceased but to accept his decisions as to whether or not he would take or not take any recommended antipsychotic medication, do you agree with that, Professor Nielssen?

WITNESS NIELSSEN: Yes I do. Yeah, whether or not greater attempts could have been made to persuade him based on long, long association is another matter. But in answer to your question, the answer is yes.

LYNCH: Professor Heffernan?

WITNESS HEFFERNAN: The answer is yes. I, I think that he hadn't reached the threshold for an involuntary assessment. However, I do not that the examination authority, which can be taken out by a psychiatrist, part of the Mental Health Act in Queensland which we were just talking about, does have a criteria about concerns about does have a criteria about concerns about, you know, further mental deterioration, so that would be in the spectrum of options. But I think that really the principles of the Mental Health Act are voluntary assessment is, is what we're shooting for every time, and so I don't think there was a time in the care with Dr Boros-Lavack that the involuntary criteria had been met.

LYNCH: Thank you. Professor Harris?

WITNESS HARRIS: I agree that Dr Boros-Lavack would have had to have gone along with Mr Cauchi's wish to continue to decrease and stop the medication. However, it would be reasonable to have demonstrated greater efforts to try and institute subsequent aripiprazole or brexpiprazole when she thought that that may have been, that may have been warranted. However, I don't think that could have been enforced in any sort of involuntary way.

LYNCH: Professor Large?

WITNESS LARGE: He was a voluntary patient.

HER HONOUR: Sorry, what was that?

WITNESS LARGE: He was a voluntary patient. Couldn’t have been made involuntary.

LYNCH: In those circumstances, his autonomy had to be respected?

WITNESS LARGE: Yes.

WITNESS HEFFERNAN: Yes.

LYNCH: Do you agree?

WITNESS NIELSSEN: Yes.

LYNCH: Is it reasonable to expect that mental health experts, experienced psychiatrist and credentialled mental health nurses should substitute their own direct assessments of a patient with the feelings or observations of a patient's mother? And I'm referring in this case to Mrs Cauchi and her observations in November 2019. Let me put it this way, you would expect competent psychiatrists and clinicians to take into account seriously the feelings and observations of a close relative like Mrs Cauchi, agreed?

WITNESS NIELSSEN: Yes.

WITNESS HEFFERNAN: Yes.

LYNCH: Would you expect clinicians of experience and competence to replace their own clinical assessments as to whether there's been a relapse of psychosis or not with the feelings and observations of a close relative, such as Mrs Cauchi?

WITNESS LARGE: No.

WITNESS HARRIS: I think it's reasonable that they, that the clinicians should have taken on board the observations of the mother and had been more suspicious and to have looked at the evidence that she was presenting at that time.

WITNESS HEFFERNAN: Yeah, and similarly I, I think that in any assessment you have to triangulate your data, which means you have a piece of information, which is your own assessment and then you have other pieces of information, and that will include a past history, and it will also include the collateral information you obtain from other sources. I don't think we should underestimate how important that collateral information was, and so I think it would be reasonable to combine that information with your assessment and inquire along, along the lines with an element of suspicion about relapse.

LYNCH: Thank you. Professor Nielssen?

WITNESS NIELSSEN: Yeah, I agree with both, with all my colleagues there. I mean you want to look at a person's longitudinal care rather than a snapshot assessment, and have a higher index of suspicion with that kind of collateral information that's for sure.

LYNCH: Looking at the longitudinal care that the Mi-Mind Centre provided to Mr Cauchi over the period 2012 to 2020, would you expect the clinicians who saw him, including Dr Boros-Lavack, I think at least two other psychiatrists and several experienced mental health nurses to form a capacity to well understand if their patient who they'd seen jointly over several, I think at least 24 times on average a year over the eight years, so more than a hundred

consultations between them, do you think they would have the capacity to identify whether Mr Cauchi was masking his symptoms if he was suffering symptoms of relapse into psychosis?

WITNESS NIELSSEN: Yes, I would imagine so. I imagine they'd be quite attuned to change, especially having made the change of stopping medication, that'd be pretty suspicious and looking closely for, for signs of relapse.

LYNCH: Professor Heffernan, do you agree?

WITNESS HEFFERNAN: I'd agree that, that they're in a very good position to make those determinations. One variable that does impact is, is the quality of that assessment. So the time you get with a person, their willingness to engage with you, and their willingness to share information, and that's why it's so important to triangulate your data, to see whether what you're seeing in front of you is the whole picture.

LYNCH: Professor Harris?

WITNESS HARRIS: They were in a very good position and had a great deal of experience. They also were very keen for Mr Cauchi to get on with his life, which may have been made more problematic by, by a relapse, but they were certainly in the best position.

LYNCH: Professor Large?

WITNESS LARGE: Sorry, just going back to the former question, you said replace - whether clinical judgment should replace - should be replaced by corroborative history, and I, I just think the answer to that is straightforwardly no, it shouldn't be replaced. It should be supplemented perhaps but not replaced. I think they were in a very good position to assess his mental state, and I don't think there's any evidence actually that it was assessed incorrectly.

LYNCH: Do you consider that the treatment provided by Dr Boros-Lavack and the Mi-Mind Centre staff met the accepted standards applicable to private psychiatrists throughout the period of 2012 to 2020? Professor Nielssen?

WITNESS NIELSSEN: I believe so. I mean it was exemplary, it was above and beyond really up until the end. It was just the, the handover was care was, there were some shortcomings there.

LYNCH: Professor Heffernan?

WITNESS HEFFERNAN: No, I agree. I mean I think there was really good care for seven, eight years, maths is poor at the moment, but I think that the majority of the care was really well managed. The one area that I think could have been improved was that discharge handover.

LYNCH: Professor Harris?

WITNESS HARRIS: I agree.

LYNCH: Professor Large?

WITNESS LARGE: I think it was well within the acceptable standard of care.

LYNCH: Thank you Professors.

HER HONOUR: Ms Mathur?

MATHUR: Yes, I'll be brief. Can I ask that Dr Hester Wilson's report be drawn up. Doctors and Professors I'm drawing your attention to a peer review expert, a Dr Hester Wilson, who has provided a report in this inquest for the State Coroner's benefit, and it's at page 22 of the brief, or 21 of her report. We've heard a number of, there's been a number of discussions in relation to persuading a patient to engage and/or missed opportunities, and I wanted to draw your attention to lines 515 through to 522, where Dr Hester Wilson gives this opinion:

> "It is important to allow people autonomy to manage their own lives, medical conditions and medications. At the same time we need a system that can respond appropriately when a person becomes unwell and potentially a risk to themselves or others.
>
> The intersection between autonomy, his human right to self-determination and compulsory treatment is controversial While Mr Cauchi was noted to be very odd to deal with by staff in the fertility clinic, his mother expressed concerns regarding his stability in late 2019 and he was noted to have poor eye contact with poverty of thought or guarded with respected affect by Dr Sarkar. He was not unwell enough to be detained under a jurisdictional Mental Health Act."

I understand your collective unanimous opinions to be in agreement, firstly with the last statement that prior to the unfortunate tragedy in April of last year there was not an indication for him to be detained under a jurisdictional Mental Health Act, is that correct?

WITNESS LARGE: Yes.

WITNESS HEFFERNAN: Yes.

WITNESS NIELSSEN: Well apart from--

MATHUR: And is it fair to--

WITNESS NIELSSEN: Excuse me, apart from the January 23 consultations. The other ones weren't of sufficient detail to identify grounds, but on that occasion I believe he could well have been taken for an assessment.

MATHUR: Taken for assessment, but not necessarily detention as an involuntary patient?

WITNESS NIELSSEN: Again, that would have been for the person performing the assessment to adjudicate, with all the information available to that doctor.

MATHUR: You're referring to a point in time where he's seen by two police officers on 8 January 2023 outside of his home?

WITNESS NIELSSEN: Correct. When sufficient information emerged that would have met criteria for involuntary treatment.

MATHUR: Is there a unanimous view amongst you that one of the principles of caring for a man who has schizophrenia or any patient with schizophrenia, including general practitioners, is to always be mindful of that person's autonomy, and their human rights?

WITNESS HEFFERNAN: Yes.

WITNESS LARGE: Yes.

MATHUR: Can I now move from that and draw up Dr Nielssen's report, and I'm commencing with you Dr Nielssen because it's a matter you in fact raised in your report, and it's in the final two paragraphs of your report, tab 10. And it's where you give an opinion, which you have also in your sworn evidence, with respect to a personal opinion held by you that a person with a mental illness such as Mr Cauchi's should not be permitted to have access to firearms?

WITNESS NIELSSEN: Yes.

MATHUR: I note that your signature has the initials FRANZCP, namely that is short for Fellow of the Royal Australian and New Zealand College of Psychiatrists?

WITNESS NIELSSEN: Yes.

MATHUR: And I did note that the other panel members are also all Fellows of the College, correct?

WITNESS LARGE: Yep.

WITNESS HEFFERNAN: Yes.

MATHUR: Dr Nielssen I'll start with you. When you gave that, and I'm just going to call it a personal opinion at the moment, when you gave that personal professional opinion, were you aware of the fact that the College, namely is it correct to define them as the peak body for psychiatrists in Australia?

WITNESS NIELSSEN: It's, actually it's the, it's the, the body that approves

people's qualifications, their training--

MATHUR: Yes.

WITNESS NIELSSEN: --that's the main function of it.

MATHUR: Peak body, reputable body?

WITNESS NIELSSEN: Yes.

MATHUR: When you wrote your report and gave that opinion both in paragraph 156 and then in paragraph 157 where you say again that in your opinion people with that condition, namely schizophrenia, should not have access to firearms, were you aware of the existence of a professional practice guideline 23, titled "Firearm Risk Assessments" published by the College?

WITNESS NIELSSEN: No, I just saw that for the very first time, and Dr Heffernan's papers. I was shown an earlier draft which I sent a very strong dissenting opinion and the whole idea that psychiatrists could do snapshot assessments and say that you're fit forever for a firearm just seemed very troubling, and, and what's come out looks very different. I haven't read it in detail yet, looks very different to the draft I was shown, but it still doesn't, you know, it still doesn't meet my - it still suggests that psychiatrists are the guys to do it, which is troubling.

MATHUR: Yes, so I mean implicit in the guideline is the fact that on a case by case basis the psychiatrist is permitted to make an assessment with respect to not lifelong access to firearms but individual case scenarios with respect to firearms. Do you agree that's implicit in the existence of the guideline?

WITNESS NIELSSEN: Yes.

MATHUR: I noted that each of the other members of the panel have also expressed their opinion against access to firearms for people with schizophrenia in your oral evidence today. Professor Large is desperate to say something?

WITNESS LARGE: I, I don't think my opinion should be taken very seriously because I, I don't believe there are any culinary reasons why a person should own a long-pointed knife of any sort, and I don't believe there are any reasons why an Australian citizen should have access to a firearm. And I also don't believe that there should be specific legislation singling out people with mental illness. I think that puts us in conflict with, you know, the United Nations Convention on the Rights of People with Disabilities. So I, I, I think I'm sort of out of this a little bit.

MATHUR: Well, only in that the College does provide for members with your opinion, namely that the guideline itself states that if you have a strong ethical bias you should refer the person to another suitably trained psychiatrist for the assessment.

WITNESS LARGE: I have done that.

MATHUR: So can I ask this, given that the peak body, your College, puts out a guideline, would it be fair to say that the State Coroner should approach her task with respect to this issue by complete deference to the College's guideline as compared to each of your individual views with respect to the appropriateness of a person with schizophrenia having access to firearms in whatever circumstances, be that supervised or unsupervised?

WITNESS LARGE: Not at all, because if firearms had been acquired, this could be so much worse and the purpose for getting it - he was already searching for, you know, serial killer kind of situations or mass killing kind of situations in 2022. You can perhaps infer that these ideas were present before that and, and it would've been so much worse. And the - that, that, that College position was written by, you know, like, a handful of our colleagues, not by us and, and people who make a living from doing these assessments as well, you know, which again is a conflict of interest. So I, I, I really don't - I think it's quite well within the, the ambit of this inquiry to consider the public safety that might be affected by people with unstable mental illness owning guns.

MATHUR: So your position - the other members of the panel, do you share the same position as Dr Nielssen that there shouldn't be a deference to the current guideline and it should be - if the State Coroner chooses to do so there should be a questioning or re-examination of the appropriateness of firearms in the possession of a person with schizophrenia?

WITNESS HEFFERNAN: Can I just clarify? I think--

DWYER: Can I object at this stage, your Honour? It's common for this Court to make suggestions as to amendments of the guidelines including that are put out by various colleges, so there's nothing unusual with an expert expressing a view that a guideline should be amended, with respect.

HER HONOUR: That's true.

MATHUR: And I'm inviting them to put their position clearly so your Honour is best informed. Professor Heffernan?

WITNESS HEFFERNAN: No, I was just going to say I think you missed an important term, which was the term "treatment-refractory schizophrenia" or "treatment-resistant", sorry, schizophrenia. So that's an important qualifier and, you know, by, by definition, you know, that's going to be a person that's got symptoms and that's unwell. But it's, it's not a dichotomous question because it doesn't exclude that person from having an assessment. And the assessment should consider does this person have treatment-resistant schizophrenia? That's part of the assessment.

And as you heard today, there can be, there can be actually differences of

opinion about whether somebody has treatment-resistant schizophrenia or not. And what this guideline actually requires is that all available information, history and - is taken into account, and so I don't think they're mutually exclusive issues.

MATHUR: Only that your opinions as expressed were more global in the sense that you held a belief, and just looking at your opinion, Professor Heffernan, that a person with treatment-resistant schizophrenia should not?

WITNESS HEFFERNAN: Yeah, so if, if a person's got treatment-resistant schizophrenia they're, they're going to have symptoms and those symptoms are going to include at times positive symptoms. They're going to include negative symptoms. And they're going to include cognitive deficits. And as we discussed earlier in the day, that also includes impacts on organisation, abstraction, planning, and these are all things that can impact on decision-making. And when, when it comes to, to firearms, the risk with weapons and firearms in particular is, is really significant.

MATHUR: They also have relapse, correct? Sorry, remission. There'll also be periods of remission, which this guideline provides for, correct?

WITNESS HEFFERNAN: Yeah. That's why I think, you know, that, that really it's very important to be clear about what, what we're talking about and that does require a thorough assessment.

MATHUR: It's fair to say in relation to the psychiatrist who assessed Mr Cauchi in January 2021 in relation to his request for access to a firearm only within a pistol club under supervision, it's correct to say at that point in time the College had no guidance or guideline in place to assist a practitioner in those circumstances? Assume this is the first it came out in September 2023.

WITNESS HEFFERNAN: I'm actually not sure about that.

WITNESS HARRIS: I can't remember any previous one.

MATHUR: Professor Large, do you recall--

WITNESS LARGE: I'm not aware of any, I'm not aware of any guideline.

MATHUR: Sorry?

WITNESS LARGE: I'm not aware of any guidelines but the general expectation that a psychiatrist can, you know, tell what a person's going to do with a firearm is overplaying the extent of psychiatric knowledge. So I'm not - I know that's not what the current guideline or the task that's set to us is, but I think I've expressed my view that it's actually - psychiatry's better off out of this.

MATHUR: The guideline does in fact say that there's an issue with psychiatrists making assessments on whether a person is a fit and proper person. Dr Harris, was there anything else?

WITNESS HARRIS: No, I haven't read this guideline so I don't think I'm in a position to, to comment.

MATHUR: Thank you. Nothing further, your Honour.

HER HONOUR: Court 2, does anyone have any questions for our experts?

CALLAN: Yes, your Honour, just briefly, thank you. I do seek to keep as brief as I can. I appreciate the late hour. My name is Sophie Callan, I appear on behalf of the New South Wales Commissioner of Police. Professors and doctor, to the extent that in your evidence you've offered a view about how first responders might benefit from mental health practitioners, such as a co-responder model, can I firstly ask, have any of you personally been involved in the delivery of assistance to first responders, for instance, through a co-responder model?

WITNESS NIELSSEN: No.

WITNESS: Yes.

WITNESS HARRIS: In the past with, with - in a community mental health setting, yes.

WITNESS LARGE: So, I'm a former Director of Psychiatry in the eastern suburbs of Sydney. And we - in some of the police districts have had a PACER model, which stands for - I'm not sure, Police and Ambulance - I can't remember exactly what it stands for.

WITNESS HEFFERNAN: Clinical Early Response.

WITNESS LARGE: Clinical Early Response. So, we've had it in some of our police areas, but not others.

CALLAN: And it - so, is it correct to say that having regard to your instances of personal experience or not with those models, you were otherwise offering these views drawn from your experience with respect to the treatment of mental health in the community?

WITNESS LARGE: Yes.

CALLAN: It seems, if I can draw it together, that you've collectively offered a compelling series of points which certainly favour the involvement of mental health practitioners as early as possible in relation to a person in mental health crisis, would that be correct?

WITNESS HARRIS: Yes.

WITNESS HEFFERNAN: Yes.

WITNESS NIELSSEN: Yes.

CALLAN: It also seems, and I don't want to put words into your mouth, that you seem to favour a response to a person in mental health crisis, which would not necessarily involve a police officer unless that was warranted. For instance, there was an investigation of a crime at play, or in respect of the protection of people where there was a real or immediate risk to life. Is that right?

WITNESS LARGE: Yes.

WITNESS NIELSSEN: That's my position.

WITNESS HEFFERNAN: Yes.

WITNESS HARRIS: Well, I do think we have to be careful about that, because, you know, there is a model in the UK, the Right - I think it's the Right Care Right Person--

CALLAN: Right Person, yes.

WITNESS HARRIS: Yes, which has been really, you know, taken on that model of expecting health and social services to respond to acute mental health crisis situations that don't have imminent risk involved in them, which has saved many, many, many police hours, which of course that's a good thing. But some of the emerging evidence from this model also suggests that it is very tricky to get the boundaries, and there have been a number of coronials that have identified that the absence of having a police response led to a risk situation that contributed to a bad outcome.

So, so I think the principle and, and also I think we have to be clear about what you mean by "co-responder", so a co-response is, is essential anything that involves a mental health - mental health and police. And I'm just using the police models here for ease of discussion. But mental health and police working together, and that can be electronically, that can be through call centres, and that can also be on the ground, in cars. And so, so they're all co-response models. They're just different types of co-response model. Sorry, I just wanted to, to clarify that point.

CALLAN: Not at all, and it sounds as though your point is that there must be care taken with respect to what the model is seeking to achieve and in its practical application as to where to draw those boundaries, because--

WITNESS HARRIS: Absolute, absolute caution about those boundaries, because, you know, any implementation of new situations often tests the boundaries and we learn by mistakes. And so if we've got an opportunity to review evidence and look at other countries' experiences of different models,

that's worth doing so that we can try and get the balance right here in Australia.

CALLAN: Does it follow then that those instances you've referred to that you're aware of where the Right Person Right Care model may have been at play in a situation which ended up with a bad outcome, it doesn't follow that the model is necessarily to be put to one side, but rather may warrant finessing or appropriate training delivered so that those risk assessments can be calibrated appropriately?

WITNESS HARRIS: Well, that's right, and we have to be careful about - and I'm sorry to use this phrase, but I think it captures it clearly, is that we have to be careful about throwing the baby out with the bathwater, you know, in terms of, you know, losing the goal that we have in that, that, you know, police mental health collaboration.

CALLAN: Yes, thank you very much. Those are my questions.

HER HONOUR: Dr Dwyer, anything arising?

DWYER: Not at this late stage, thank you.

HER HONOUR: I would like to say a very big thank you to Professors Nielssen, Heffernan, Harris, and Large. You've been sitting there for over eight hours now answering questions and putting your mind to these incredibly important issues. This is after writing the reports, as I've said, in a very short turnaround time. I'm immensely grateful to all of you. It's been so important to have your input into this inquest, thank you.

DWYER: Your Honour, might I note that they're not off the hook yet, because they have each of them agreed to assist in relation to draft recommendations that will be circulated.

HER HONOUR: Thank you.

<THE WITNESS WITHDREW

DWYER: Your Honour, might I just clarify any confusion in relation to the non-publication order issue. With the completion of that panel, so that everything can be put in context, that now will result in an expiry of the interim non-publication order in relation to the name of Dr Boros-Lavack, Dr Parkar and the Mi-Mind Centre nurses. After we rise, we start again tomorrow again with two panels, but we commence at 10am tomorrow.

AUDIO VISUAL LINK CONCLUDED AT 5.14PM

ADJOURNED PART HEARD TO FRIDAY 23 MAY 2025