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IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

FRIDAY 23 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.08AM

AUDIO VISUAL LINK TO ENGLAND COMMENCED AT 10.08AM

HER HONOUR: Good morning.

SULLIVAN: Good morning your Honour. As your Honour knows, we have the emergency physician conclave. And before I ask your Honour to have sworn in the conclave panel members, I'd like to tender some material that relates to the evidence that they will go to.

HER HONOUR: Certainly. Have a seat. You'll be asked to stand again shortly, but have a seat for now. Thank you gentlemen. And I see that Dr Cowburn--

SULLIVAN: Dr Philip Cowburn is on the screen.

HER HONOUR: Yes, we'll be coming to you shortly. Thank you for making yourself available.

COWBURN: My pleasure ma'am.

SULLIVAN: Your Honour, the material to be tendered, and it's been handed up to your Honour in a volume, is firstly at tab 625B, the supplementary statement of Ambulance Officer 1, dated 15 May 2025. Secondly at tab 1606A, a supplementary statement from Dr Thomas Evens, who is of course a panel member. There is also a further report from Dr Philip Cowburn to tab 22A. That's primarily focused on JESIP principles, and Dr Cowburn has also provided some reference materials. That's proposed to go in as an MFI at this point in time; there's a particular document that may have some sensitivity.

There's also a replacement copy of Dr Mazur's reports that just corrects, in effect, some formatting matters, that will replace tab 18 in the expert volume, and then there are some aide memoires that we'd seek be marked for identification at tab 7 to 12 of the index. A copy of the index will be provided to my friends. I don't need to dwell further on that. And I should also indicate

we'll provide an index with the material that the panel received for their consideration having undertaken a discussion on 20 May on a range of topics where there is largely agreement on all issues.

HER HONOUR: Thank you Ms Sullivan.

SULLIVAN: Now if we could swear in these panel members.

HER HONOUR: Yes.

SULLIVAN: I should indicate they are Dr Stefan Mazur, Dr Thomas Evens and Dr Philip Cowburn.

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<PHILIP COWBURN, AFFIRMED, AND STEFAN MAZUR AND THOMAS EVENS, SWORN(10.11AM)

SULLIVAN: The first matter that I'm going to go through with each of you is your background, your current role. I'll start with you Dr Mazur. Can we have your full name please?

WITNESS MAZUR: Yeah Stefan Mark Mazur.

SULLIVAN: Before I go any further in relation to your background Dr Mazur, I understand there is something you would like to say on behalf of the panel to the families who are watching these proceedings?

WITNESS MAZUR: Yes thank you. Before we'd start, Tom, Phil and myself would like to acknowledge all those people directly impacted by this terrible event, particularly to the friends and family of the people who died. We want to offer our heartfelt sympathy and condolences.

SULLIVAN: Thank you Dr Mazur, Dr Evens and Dr Cowburn. Now Dr Mazur, your current role?

WITNESS MAZUR: Yes I work as an emergency physician at the Royal Adelaide Hospital, and also as a pre-hospital retrieval physician with SAAS MedSTAR which is the State-based medical retrieval service, and as a medical retrieval consultant for that service.

SULLIVAN: And you've been an emergency physician since 2003?

WITNESS MAZUR: Yes.

SULLIVAN: And you've been a pre-hospital and retrieval medicine doctor since 2006?

WITNESS MAZUR: Yes.

SULLIVAN: And you spent a period working in the UK for the London Helicopter Emergency Medical Service in pre-hospital trauma care, correct?

WITNESS MAZUR: That's correct.

SULLIVAN: How long was that period?

WITNESS MAZUR: It was a period of about seven months.

SULLIVAN: You were previously the Chief Medical Officer for the South Australian Ambulance Service from 2012 to 2016?

WITNESS MAZUR: Yes.

SULLIVAN: And you hold an academic position, an Associate Professorship at

James Cook University?

WITNESS MAZUR: That's correct, yes.

SULLIVAN: You've provided an expert report for these proceedings initially dated 26 March 2025, but some formatting matters are corrected?

WITNESS MAZUR: Yes.

SULLIVAN: Any other changes to that report?

WITNESS MAZUR: No.

SULLIVAN: Okay, thank you. Dr Evens, can we have your full name?

WITNESS EVENS: My name is Thomas Peter Evens.

SULLIVAN: And your current role please?

WITNESS EVENS: I am the Acting Executive Director of Medical Services and Research at New South Wales Ambulance.

SULLIVAN: That's a role you've held since March 2024?

WITNESS EVENS: That's correct.

SULLIVAN: All right.

WITNESS EVENS: I'm also an emergency physician at the Northern Beaches Hospital, and I'm a Senior Staff Specialist in aeromedical retrieval, also with New South Wales Ambulance.

SULLIVAN: From the period 2014 to 2019, you were the Assistant Medical Director for London Ambulance Service?

WITNESS EVENS: Yes.

SULLIVAN: And you were a consultant for the London Air Ambulance Service from 2016 to 2019?

WITNESS EVENS: Yes.

SULLIVAN: And you have completed national ambulance resilience tactical command course training?

WITNESS EVENS: Yes.

SULLIVAN: When did you do that?

WITNESS EVENS: 2018.

SULLIVAN: And I assume that incorporated some notions of the JESIP doctrine?

WITNESS EVENS: Very much.

SULLIVAN: And you were the Medical Advisor on scene at the 2017 Westminster Bridge terror attack on London?

WITNESS EVENS: Yes.

SULLIVAN: You were the hospital emergency department Resuscitation Commander at the 2017 Grenfell incident in London?

WITNESS EVENS: Yes.

SULLIVAN: In fact you obtained your medical degree in 2004?

WITNESS EVENS: Yes.

SULLIVAN: And became a Fellow of the Royal College of Emergency Medicine in 2012?

WITNESS EVENS: Yes.

SULLIVAN: You've prepared two statements for the purposes of these proceedings. The first is dated 26 March 2025, the second dated 13 May 2025. Any corrections to make to those?

WITNESS EVENS: No.

SULLIVAN: Thank you. Dr Cowburn, your full name please?

COWBURN: My name is Philip John Cowburn.

SULLIVAN: What's your current role, Dr Cowburn?

WITNESS COWBURN: I have a portfolio career which includes consultant emergency medicine at Bristol Royal Infirmary in the southwest of England. I am consultant trauma team leader at North Bristol Hospital which is the regional major trauma centre in Bristol. I am a Medical Director with Southwest Ambulance Service, one of the largest regional ambulance services in the UK. And I am the medical director for the NHS Resilience Emergency Capabilities Unit which was formerly known as the National Ambulance Resilience Unit.

SULLIVAN: You obtained your medical degree in 1993 and have been involved in pre-hospital care since 2004?

WITNESS COWBURN: That is correct.

SULLIVAN: You obtained your Fellowship in Emergency Medicine in 2008?

WITNESS COWBURN: Correct.

SULLIVAN: You've given expert evidence at the Manchester Arena Inquiry into the terrorist bombing at Manchester Arena in 2017?

WITNESS COWBURN: That is correct.

SULLIVAN: You've also given expert evidence to the Dawn Sturgess Inquiry into the Novichok poisonings in Salisbury and Amesbury in 2018, correct?

WITNESS COWBURN: That is correct.

SULLIVAN: You are a qualified Ambulance Commander at the operational, tactical and strategic levels within the JESIP model?

WITNESS COWBURN: That is also correct.

SULLIVAN: You have responded to over ten major incidents that would be comparable to the one the subject of this inquest in a clinical or command capacity in your region, is that accurate?

WITNESS COWBURN: That is also accurate, thank you.

SULLIVAN: Thank you. Before we turn to some particular topics, you had the opportunity to meet as a conclave on 20 May, that's correct?

WITNESS MAZUR: Yes.

SULLIVAN: A number of questions were put to you and you were able to, in effect, reach agreement as to all matters, correct?

WITNESS MAZUR: Yes.

WITNESS COWBURN: Yeah.

SULLIVAN: The agreement that was reached was distilled in a summary table document with which you all agree?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yeah.

SULLIVAN: Dr Cowburn--

WITNESS COWBURN: Yes.

SULLIVAN: --you agree? Your Honour, I tender--

WITNESS COWBURN: I agree.

SULLIVAN: --a copy of that - I'm sorry, Dr Cowburn, did you--

WITNESS COWBURN: I do, yes.

SULLIVAN: Thank you. I tender a copy of that table.

EXHIBIT #7 JOINT EXPERT CONCLAVE SUMMARY TABLE BETWEEN DOCTORS COWBURN, EVENS AND MAZUR TENDERED, ADMITTED WITHOUT OBJECTION

SULLIVAN: Now before we deal with the issues addressed by you as a conclave, as a panel, I'd like to just start with the matters that come out of the final page of Dr Mazur's report where he comments on the skill, the competence and the expertise of all the emergency services personnel who attended on 13 April, and Dr Mazur makes the point that they undertook their task in the most trying of circumstances, and that these incidents are fortunately very rare but it's imperative that all learning be taken from this incident. Is that your view as a panel?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

WITNESS COWBURN: Yes.

SULLIVAN: Dr Cowburn, are there even potential learning for you to take on board in your role in the UK from this incident?

WITNESS COWBURN: There are indeed. There are many factors particularly displayed by New South Wales Police Force and New South Wales Ambulance which are highly commendable, and I would be keen to take that learning from the tragic events and share that within the UK if I may.

SULLIVAN: Thank you. You make the point that this is a critique of the response of in particular the New South Wales Ambulance Service, but it's not to be taken as a criticism, correct?

WITNESS COWBURN: That is correct. That is correct, yes.

SULLIVAN: Is there agreement amongst the panel that we must caution against hindsight bias as we sit here in the safety of a courtroom assessing matters?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yeah.

WITNESS COWBURN: Undoubtedly, yes.

SULLIVAN: There was agreement as set out in the table - this is the first matter - as to the principles that are best practised medically or clinically for dealing with penetrating trauma wounds, that's so? That's as set out in Dr Mazur's report, all agreed as to the principles?

WITNESS EVENS: Yes.

WITNESS COWBURN: Yes.

SULLIVAN: I'm going to touch on this matter in very short form, that's the issue of the survivability of the victims; there's complete agreement on this topic as I understand it. But for the record, firstly, I understand there is agreement as between you with your expertise that the injuries sustained by all victims, with the exception of Faraz Tahir who we'll separately deal with shortly, that those injuries were un-survivable in the sense that even had pre-hospital care of the most eminent level been available at the time, none of the victims could have survived. Is that agreed as between you?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

WITNESS COWBURN: Yes.

SULLIVAN: The second issue related to that is the status of Faraz Tahir. Is it fair to say that there was some movement, based on your conclave discussions on 20 May, as to how that issue ought be best dealt with?

WITNESS EVENS: Yes.

SULLIVAN: The formulation that was agreed was to this effect, that:

> "The injuries sustained by Faraz Tahir meant that he was extremely unlikely to survive, even with immediate access to the highest level of pre-hospital critical care working in a well-structured trauma system with rapid access to theatre or surgical intervention."

That's your agreed position?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

WITNESS COWBURN: Yes, it is.

SULLIVAN: Can Faraz Tahir's family have confidence that absolutely everything that could have been done was done for him?

WITNESS EVENS: Mm.

WITNESS MAZUR: Yes.

SULLIVAN: Dr Mazur, do you agree?

WITNESS MAZUR: Yes.

SULLIVAN: Dr Cowburn?

WITNESS COWBURN: I, I agree. I think the level of care delivered to Faraz was of an exceptionally high standard and should be commended.

SULLIVAN: Thank you. The third matter that you discussed was the question of the New South Wales Ambulance command and control structure. A number of issues were raised in Dr Mazur's report, in particular at paragraphs 207 through to paragraph 222, during that initial phase of the incident, that is from the period 3.50 to 4.20. I don't work with a 24 hour clock, so just be warned. So in effect, the panel agreed with the matters that were raised by Dr Mazur's report in those paragraphs?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

SULLIVAN: Dr Cowburn?

WITNESS COWBURN: Yes. Yes.

SULLIVAN: Dr Mazur, can I just get you to speak to the particular issues if I could. Please feel free to refer to your report as you need to, but, for example, at paragraph 207 to 211.

WITNESS MAZUR: Sure. It, it appeared to me, from the statements that I read from both paramedics - mainly from the paramedics that attended, that the, the initial actions on the scene were occurring inside Bondi Westfield. That, that the most senior clinician there had established himself as a Forward Commander within the area. There was an interaction between the next most senior clinician to arrive from Ambulance, which was an opportunity at that stage for them to I guess confirm the roles that they were going to take and how they would undertake that, with one staying inside to help manage the scene inside Bondi Westfield, and the other to exit and ideally to set up scene infrastructure requiring their ongoing triage, treatment and transport of the extricated casualties.

It seemed there was - from my reading, that there was a degree of - what's the word - a degree of maybe confusion is not - maybe not the word, or just uncertainty as to what those - who was going to undertake what roles at that stage, such that outside of the Bondi Westfield, there may have been a period of time where the scene - the setup for ongoing scene management may not

have been as rapidly progressed as it potentially could have been, taking into account the, the chaos of the environment.

SULLIVAN: Do you agree with that, Dr Evens?

WITNESS EVENS: I do. I would also add that the first responding potential Commander must assess the scene and make what they believe to be the best decision to effect care for the patients and establish command within the resources they have available, and I do not see any other, other, other choice available to Officer Simpson but to enter the complex, and I believe that was absolutely the right choice. A consequence of that is that he was not therefore physically able to fulfil some of the other roles of an Ambulance Commander, and, and I agree that there was a period of time, as people arrived sequentially from different directions, where there may be an opportunity to - for the subsequently arriving people to establish a command structure, again cognisant of the fact that it appears very easy in retrospect to say that.

SULLIVAN: Yes, and that can be accepted as a general proposition for all these assessments. Dr Cowburn, do you have a comment to make?

WITNESS COWBURN: I, I very much concur with my colleagues on this. I think Officer Simpson should be congratulated on a very patient-focused and mature attitude towards risk, and I think his initial actions are extremely commendable in enabling care to be delivered to those injured patients. The, the confusion and chaos that will always surround one of these incidents becomes the area where command needs to - we've used the term "get a grip" on the situation, and I think there was a period in which this could have been improved, but as I've already stated, I think this is more of a critique than a criticism of the events that unfolded.

SULLIVAN: It's fair to say that the decision by Inspector Simpson which you describe in your second report at tab 22A, his decision to deploy saved lives?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes, yeah.

SULLIVAN: The panellists are nodding.

WITNESS MAZUR: Yeah.

SULLIVAN: Dr Cowburn, you agree? It's in your report.

WITNESS COWBURN: Undoubtedly.

SULLIVAN: But ultimately, these command and control issues that you have agreed upon as a panel feed into broader systemic issues as to the New South Wales Ambulance command and control structure firstly, and secondly, interagency workings, agreed?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yeah, and to a degree to the AMPLAN itself, or the incident management plan itself which sets out the requirements for each position, but they, but they may - but they were clearly not obtainable in this circumstance, that the, the two things were almost a counterproductive, fighting against each other, the scene itself and the roles that were required for, for when Officer Simpson was inside.

SULLIVAN: There were particular challenges that presented in terms of that scene. Can I ask you, Dr Mazur, to identify those?

WITNESS MAZUR: The challenges were, were huge. So three levels, patients inside shops, outside shops, loud siren, people trying to exit, police trying to enter, difficulties with communication, it's a - yeah, it's an extraordinarily challenging scene. Extraordinary.

SULLIVAN: You would have read the evidence of Inspector Simpson that in fact the siren was so loud that he was forced to use hand gestures to communicate with his paramedic teams?

WITNESS MAZUR: Yes, and, and I was able to also view some body-worn video which had sound on it and, and you could tell from that that communication was extraordinarily difficult.

SULLIVAN: Any further matters to draw out, Dr Evens, in terms of the scene?

WITNESS EVENS: May I also add that the nature of the behaviour of the public, including people who were injured in a marauding terrorist attack, is very naturally to move from the scene, and therefore for someone trying to establish command, they have patients who may not be physically at the location of the incident but are still part of the incident and require management, and this is all unknown to the Commander as they begin.

SULLIVAN: A marauding terrorist attack is the UK terminology, MTA, but in our language, it would be an active armed offender?

WITNESS EVENS: Yes, correct.

SULLIVAN: Is that based on your experience in particular of the Westminster Bridge attack?

WITNESS EVENS: Yes, it is.

SULLIVAN: Dr Cowburn, do you have a comment?

WITNESS EVENS: I concur with my colleagues on the panel. These incidents are always incredibly dynamic and fast-moving, and it is exceptionally difficult to get an initial understanding of what is going on, both with the movement of patients and of people and of responders.

SULLIVAN: Flowing from your assessment of command and control, there were some specific recommendations that arise in connection with the New South Wales AMPLAN and we understand it is under review, that's consistent with your understanding, Dr Evens?

WITNESS EVENS: Yes.

SULLIVAN: Dr Mazur, you made a number of recommendations in terms of some pragmatic matters, for example, the visual identification of key roles, the use of action cards, and the like. These matters are addressed at pages 11 to 12 of your summary from the pre-conclave meeting, in particular on page 11. Can I ask you just to speak to those matters, please, Dr Evens?

WITNESS EVENS: So, this discussion related to the ability of people who were arriving on scene to understand clearly who was in command or who was in which role. The nature of a response to a rapidly evolving incident is that as people arrive, roles are filled, and secondarily, apart from visually, it can be very difficult for people to identify who is in command. The difficulty therefore is that people who might fill any role need to have with them the tabards or other identifiers that could allow them to be identified in any one of a number of roles.

Therefore, we discussed particularly how in the United Kingdom the tabard for a command role is very visually different to the tabards for all of the other roles, and that this offers some value in that system, the reference really being that the command roles have a checkerboard pattern on them.

SULLIVAN: We're in a position to pull up an example of that, if that's of assistance. This is the NARU Command and Control document at page 52.

WITNESS EVENS: I think that's relevant, because any approach to major incident management that assumes that the people who are responding will have full situational awareness or will have the cognitive capacity to reason in the way that they would normally has been found serially to be overoptimistic.

SULLIVAN: Yes.

WITNESS EVENS: And that things must be pre-understood. There should be both a common visual and, where necessary, technical language, both between the emergency services and within services so that people who are under extreme pressure can come to the right conclusion quickly whilst they are dealing with other things. And so, this is an example of an approach, but the principle that the tabards and the labels should make it easy to tell who is in which role when they might move between roles is an important one.

SULLIVAN: Just to be clear, we see the yellow and green checker is the ambulance connotation from those particular tabards?

WITNESS EVENS: Green and white checker means ambulance. So, the Fire

Commander will have a red and white checker.

SULLIVAN: Yes, and police are blue and white?

WITNESS EVENS: Yes.

SULLIVAN: Then the colours down the bottom, what do they signify?

WITNESS EVENS: So, if you looked at the top one, the white is Incident Commander.

SULLIVAN: Yes.

WITNESS EVENS: And that will be true of the Fire Commander and the Police Commander, and then the other colours relate to the specific roles underneath that person.

SULLIVAN: Across the services?

WITNESS EVENS: I would defer to Dr Cowburn with more current information.

SULLIVAN: We might do that actually. Dr Cowburn, this has come from the document you were kind enough to provide. That's the National Ambulance Service, Command and Control Guidance dated February 2024. Can you speak to how the tabard system works currently?

WITNESS COWBURN: So, the tabard system works with the shoulder piece of the tabard being checkered, and that is a fluorescent checkered so it can be seen in low light. And as Dr Evens has said, the fire service will have a red and white checkerboard, the police will have blue and white, and ambulance will be green and white.

The lower half of the tabard will define what that role is. So, you will see there that the Medical Incident Advisor will have a red lower half, and this just makes it very easy to find the person that you want at some distance. Police and Fire have a similar structure, with the Lead Commander having the plain white bottom and Safety Officer again having the blue. So, there is a degree of overlap, but obviously within certain forces, there are specific roles that are only within that service. So, there is an array of tabards for police and Fire Rescue, some of which will overlap with the different checkerboard top. Thank you.

SULLIVAN: Dr Cowburn, is it the case that there is training in the context of the JESIP model about what these tabards signify?

WITNESS COWBURN: There, there is. Certainly, as you become a more senior and advanced commander there will be additional training in that, and those, those tactical advisers that are trained as National Interagency Liaison Officers will have extensive training in the recognition of their emergency

service colleagues from all the services and the roles and the functions that they will deliver.

SULLIVAN: In effect, this tabard system provides a common visual language as between emergency service responders, is that right?

WITNESS EVENS: Yes.

WITNESS COWBURN: That is correct.

SULLIVAN: There's learning to be taken for the New South Wales Ambulance Service, New South Wales Police Force and other agencies in relation to the UK system, do we agree?

WITNESS EVENS: Yes.

SULLIVAN: Dr Mazur?

WITNESS MAZUR: It's been a while since I've worked in the UK, but from my colleagues, what they say, I would agree, yes.

SULLIVAN: All right, thank you. Another matter that you refer to is this notion of action cards. It comes firstly from a recommendation from you, Dr Mazur. Dr Evens, you commented on it in the context of the panel discussions. What do you think is the utility of action cards to define roles, key roles within major incident scenarios?

WITNESS MAZUR: While Tom's looking for that, it's not necessarily cards. That's an example, but some way that people, when they take on a role within an incident, have an easy checklist or - "failsafe" is a bit strong, but a way of confirming that what their roles actually are and what they need to do. Because we need to be aware - and we've already pointed out - these kind of incidents are very rare. So, they're not at the forefront of people's minds. They turn up to the incident, their bandwidth immediately gets very full, and so they need some simple way of saying, "Okay, I've been appointed to this role, now just what exactly does that role entail? That's right, that's what this role entails, check, check, check, check, check, check".

Now it may be a card, it may be some other form of technology, an app, I don't know. But some easy way that people can just double check or triple check that this is the role that I'm doing. And if they get assigned another role - because that will happen; roles can be a bit dynamic - then they can offload one of them and say, "I've done these parts, you might need to do this, what am I picking up". That allows, or helps, people under pressure achieve the tasks that fit in their role, if that makes sense.

SULLIVAN: I see. Dr Evens?

WITNESS EVENS: Yes, sorry, I was looking for my previous form of words. I agree with Dr Mazur. So cognitive aides are important for people under

pressure. There are different forms that those aides can take, I agree. So, an action card is only one form of cognitive aide. It's important to put this in the context that this is not a description for someone that has had no experience picking up a card and then taking a role. They are there as a cognitive check to enable someone who is trained to do a role to ensure that they have completed all aspects.

SULLIVAN: All right, understood. I think you made reference to an app, Dr Mazur, but we might go to Dr Cowburn, because we know that there's the JESIP app that accompanies the JESIP model. Can you comment on that scenario, please, Dr Cowburn?

WITNESS COWBURN: Thank you. So, the JESIP app interestingly does not have the action cards for the various command roles, because the JESIP app is truly multiagency and would need to have so many on there. That is something that we have been considering. There are apps that can have that on there, but you need to make sure that you have the most up to date version, or if you are getting it directly online, that you have signal.

I think from my perspective, I would very much reiterate what Dr Evens has said; that even for those of us that have delivered command or medical adviser roles for many years and get a lot of experience through exercising and training, even we, under the pressure of such an incident, will omit things. And so having this as a checklist to ensure that you have undertaken all the key aspects of that role is very important. Thank you.

HER HONOUR: Ms Sullivan, sorry to interrupt.

SULLIVAN: Not at all.

HER HONOUR: And you may have mentioned it, but we're using the acronym JESIP. It might be good for people listening to know what it--

SULLIVAN: I was just thinking that, your Honour. I am coming to that. It's a meaty subject.

HER HONOUR: Sorry, yes.

SULLIVAN: But perhaps I can ask Dr Cowburn as the expert just to explain in short form, before we deal with it in some detail, the JESIP doctrine, please.

WITNESS COWBURN: Thank you. So JESIP stands for Joint Emergency Services Interoperability Principles. Now, this is a concept that brings together how every agency at a large-scale incident, or even a small incident, can work together for the benefit of managing the scene and delivering care to those people or patients who are involved.

I'm sure we will go into it in more detail in due course, but it was set up in response to a number of incidents that occurred within the UK where individual emergency services delivered excellent care within their realm, but it wasn’t

joined up. It may be sometimes it duplicated each other's work, or it impeded each other's work, and it was felt that if they collaborated and worked together as one unit and shared information and understanding, that the benefits for patients and the scene would be much greater.

SULLIVAN: It commenced operation around 2012, is that right?

WITNESS COWBURN: That is when it was - the rollout was started. There'd been a couple of years of work in developing it before then, but it started in 2012 with a, a, a significant amount of government funding to roll it out across all three key emergency blue light services. So that would be police, ambulance and Fire Rescue.

SULLIVAN: Thank you. We'll come back to that, but can I ask please, Dr Cowburn, could we put up on the screen your second report at page - that's tab 22A - at page 43. This is where you deal with a critique, as it were, of the New South Wales Ambulance response pursuant to the New South Wales AMPLAN, making some adjustments in light of the application - or the structure that applies in the UK, that is, under the equivalent guidelines, the command and control guidelines from the National Ambulance Resilience Unit. And you've set out an analysis there right through to page 47, but can I just ask you to summarise the key points that you would raise for the consideration of those who will look at this evidence and have regard to recommendations arising from that analysis, please?

WITNESS COWBURN: Thank you. I think it is always fair to say that in the initial chaos and confusion of a large-scale incident, many plans do not fulfil how they initially intend to, and there needs to be a period of evolution and maturity within the scene to get things on track.

Within the UK, particularly within the Ambulance Service Command and Control, we have this national doctrine which covers a lot around the how Commanders act, how they interact with their colleagues from other emergency services, what training they need to undertake, assessing their competency and how they gain that competency and maintain that competency. And that will be different at different levels of the tiers of command. So, this is a national expectation such that if you have an Ambulance Service Tactical Commander in one service, they will be trained in the same concepts as they would be in any other service throughout the UK. And this gives a useful structure on which to build the regional major incident plans.

SULLIVAN: There's requirements for ongoing competency once a Commander has attained the initial command qualifications, is that right?

WITNESS COWBURN: That is correct. You are trained to a national minimum skill set, and as part of maintaining that, you have to undergo regular training and exercising, and also continual professional development to maintain that portfolio of command competency.

SULLIVAN: You say on page 44, the penultimate paragraph:

> "This allows command roles to be considered a professional standard to ensure competency and consistency. This has been subject to scrutiny at inquests and public inquiries where those acting in command capacity have been assessed against these standards."

So, in effect, it's quality assurance that those who will lead services in these major incident scenarios are well equipped to undertake those roles, that's the essence of it?

WITNESS COWBURN: That, that is correct. And I think one of the things that we have learnt within the United Kingdom over a period of time is that the competency to deliver command at incidents like this is not purely based on rank. So just because you may have a high rank within a service, particularly the ambulance service, does not mean that you are necessarily equipped and competent to deliver a command standard. That said, most high ranking officers within the ambulance service will have had command training and probably be functioning at a senior command level. But that also means that if you are a competent Commander, you could act in various different tiers. So you may have a high ranking officer acting at a - quite a low level of command, because that is where they are competent. Thank you.

SULLIVAN: I see. Do you have a comment on that, Dr Evens, based on your experience in the UK as contrasted with your experience in the New South Wales Ambulance Service?

WITNESS EVENS: I, I wholly agree with the analysis offered by Dr Cowburn in this section of his report.

SULLIVAN: Yes.

WITNESS EVENS: I think it is incumbent on emergency services to make sure that there is assurance about the individual capability of people who will be asked to fulfil a command role, and note the importance of ongoing training and credentialing in the context that that does require a significant investment of resource, and a structure to allow people who will take command roles to take opportunities for that training and particularly the co-training with other emergency services. And that assurance obligation also extends to how the system works.

And a reflection I would make on the evolution of JESIP is that I agree that the response to incidents, for example the 7/7 bombing in 2005, emergency services fulfilled their obligations within their realms. But what was apparent was that assumptions about how services would work together but also what was required for services to work together, assumptions were held which were found not to be true under what is the most strenuous of tests.

And JESIP is something that has evolved over what is now more than a

decade, where as it has progressed, assumptions are still found not to be true, even though things have improved. And I suppose the strongest reference there is the Manchester Arena Inquiry which I know has been entered into evidence here, where a relatively mature system was still found to hold assumptions which did not turn out to be true, and what that I think tells us is that proactive investment of time and structure and resource to producing a system that is credentialed and, and tested under pressure, results that when it's needed, true interoperability working is possible. And so it is not as simple as writing some principles--

SULLIVAN: Yes.

WITNESS EVENS: --on a page.

SULLIVAN: Yes. That's about the embedment of the JESIP principles within the organisation which takes money and time, and commitment?

WITNESS EVENS: I agree.

SULLIVAN: Dr Mazur, do you have a comment?

WITNESS MAZUR: I do. The - I, I'm just hopeful that I understand where we're talking about New South Wales emergency services, but I would be hopeful that these discussions are reaching a wider audience Australia-wide. Because just because a border occurs doesn't mean that the principles don't apply over a river or down the street because it's now South Australia or, or Victoria or Queensland. So it would be nice if this discussion here reaches a broader audience, and then maybe gets to a higher level of government or authority to help implement that perhaps not just New South Wales-wide, but maybe we should be looking at this Australia-wide.

SULLIVAN: Because it doesn't make sense to keep the learnings confined to New South Wales.

WITNESS MAZUR: None at all. So yeah, so, so if we can - and again, because other than Australia, or Australasia if I can throw in my homeland as well of New Zealand, we, we, we often help each other out. We go backwards and forwards, so if, if everyone's working from this same model, then that it can only make any actions much more likely to be successful because we're all speaking the same language, and working to the same philosophy.

SULLIVAN: Did you want to say something Dr--

WITNESS EVENS: May I add, applying these lessons to our environment in New South Wales and, and indeed in Australia, we should note that there are some differences in, in terms of how our population is distributed and how our resources are distributed. And as has been referenced, my experience has broadly been in a, in a highly urban setting, in London, and then the matter at hand today, also within a highly urban, and therefore well-resourced setting.

SULLIVAN: Yes.

WITNESS EVENS: And the discussion here was about how would we make best use of what are sufficient resources. I am mindful that our capability needs to be adequate across the State, and where incidents may occur in areas with either less resources, or where there are not ready access to senior members of staff.

SULLIVAN: Right, yes that's a very fair point. Did you want to comment on that from your experience of the application of JESIP in the more regional areas, Dr Cowburn, given we've cracked open the topic?

WITNESS COWBURN: Yes thank you. Obviously when I, I say I deal with a, a rather mixed region within the southwest of England between, you know, large urban cities and very rural, the, the distances are quite ludicrous if I say they are long distances compared to those that you have in Australasia. I think the concept of interoperability, if it - it probably works from the grassroots level all the way up through the command tiers to the strategic level, if it is truly embedded, works very well regardless of the region that you are, are hosting it within and the region that the, the incident is happening in.

What we need to be cautious of, as has been highlighted by some of the reports that I have quoted within my report, is that this is not a top-down diktat of what must be done. There has to be buy-in from every level to, to show that it will really work. Thank you.

SULLIVAN: Thank you Dr Cowburn. I don't need to go to the matters set out at pages 45 to 47 of your report relating to AMPLAN, we're coming back to AMPLAN briefly. But you conclude with this, based on the assessment of some suboptimal matters, to put it that way, based on the command and control structure on the day. You say this:

> "Whilst the New South Wales Major Incident Response Plan may seem to appear effective on paper, does it bear contact with an actual major incident? Is it worth considering whether the plan requires fundamental revision because of the learnings from this event, or has it proven effective at previous incidents?"

So you're raising a concern about whether in some respects it's fit for purpose. Is that right?

WITNESS COWBURN: I think I - that may be - that might be a slightly harsh interpretation of it. We all know that major incident plans are often written. They may be tested in exercising. But it is essential that we take learning from exercising and real incidents. Now, I am not aware of how this plan has performed in any, any exercising of an active armed offender, or any other incidents. It may have proven to be very well suited to other incidents, or been proven to work in exercising and it just did not work on the day. That said, regardless of whether the plan was followed or not, the delivery of care was exemplary. So I would not wish to be critical by saying the plan was not

followed, because the outcome was very well delivered.

SULLIVAN: Thank you. So those matters will be taken up I'm sure within the New South Wales Ambulance Service in terms of the critique offered at pages 44 to 47, Dr Evens?

WITNESS EVENS: Yes, the critique of it is very valuable as New South Wales Ambulance undertakes a review of AMPLAN.

SULLIVAN: Turning to a new topic, that is the triage process, and I think there was clear agreement between you - this is dealt with in topic 4 of the table - clear agreement between you as to the challenges of the triage scene, including the volume of the alarm, the layout of the victims across three separate floors, the shuttering of shops, panicked civilians and the like. But it's also accepted that there were some issues with the manner in which the triage process was conducted. That's so?

WITNESS MAZUR: Yes.

SULLIVAN: And in particular, there was no rapid sweep assessment of the scene undertaken; that was the evidence?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

SULLIVAN: And there should have been?

WITNESS MAZUR: Yes.

SULLIVAN: That's a point that you particularly drew out in your first report, Dr Mazur, and the panel is in agreement that that's a critical component of the triage process?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

SULLIVAN: And in terms of what flowed from that, there was a lack of a situational awareness of casualties because there was no rapid sweep assessment, agreed?

WITNESS MAZUR: I, I think it's, it's more - yeah, there was difficulties identifying where all the casualties were, particular(as said), the more significantly injured. And yeah we've already brought it up, but I just want to emphasise the point that it was extraordinarily difficult; noise, location, levels. And the, the, the first officer who was sort of - as part of their plan is encouraged to do that sweep wouldn't have been able to do the job that they did and do the sweep as well. They're, they're almost the two competing interests, that both couldn't be achieved. So that in itself is almost identified as

a weakness in the plan that, that Phil has alluded to. But there needed to be some way of as quickly and as accurately as possible identifying where all the most significant casualties were, and being able to either extricate or get the appropriate aid to those casualties as quickly as possible.

SULLIVAN: Dr Evens, you--

WITNESS EVENS: I, I think an important point that Dr Mazur says there is that there must be a way to establish as rapidly as possible the number and extent of casualties. In some major incidents, it is not possible for an individual to sweep through the scene, and it, it's not therefore, or should not be, an expectation that that has happened in that way. And as Dr Mazur says, it's entirely plausible that if we'd asked the person, doctor - Mr Simpson to walk through the entirety of Bondi Junction, he would not have been effective in any of the other things that he needed to do. What a system needs to do is bring to a person who is allocating the resources that they have available the information that they need. The "sweep" term I think really originated with a concept of major incidents that was based around, for example, a train crash with a scene--

SULLIVAN: A static, a static scene--

WITNESS EVENS: A static incident; walk through the scene and establish it. And certainly my recollection is when we arrived on Westminster Bridge, I could not see the end of the scene. I did not know how far the scene went or in what direction the scene went. There was no means of sweeping the scene, and what we needed to do was bring the information from the clinicians in the various areas back to the Ambulance Commander supported by the Medical Advisor.

SULLIVAN: I see, thank you. That's an apt example. Do you have a comment to offer Dr Cowburn?

WITNESS COWBURN: I, I think I - all I will be doing is reiterating the, the views that it is very difficult for a single individual to gain situational awareness of a very dynamic, spread-out environment with multiple patients. And what is key to this is understanding the scale, so the number of patients, and their severity, and the spread over which you have got those patients distributed. And that is very difficult to achieve. If you are the solo person trying to deliver that, it's practically impossible.

SULLIVAN: Right, so it's about obtaining - using the available resources to obtain that situation awareness through information?

WITNESS MAZUR: Yes.

WITNESS EVENS: Yes, and that information--

WITNESS COWBURN: Yes.

WITNESS EVENS: --being actively pushed back to the Ambulance Commander.

SULLIVAN: All right, thank you. Just in terms of drawing out the implications, I suppose, of the lack of the ability to conduct a rapid sweep assessment if we put it in those terms, that led to a delay in the triage of some patients that we know didn't impact on clinical outcome, but there was a delay. Is that agreed?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

SULLIVAN: And there was also visual assessment of some patients as being deceased without actually undertaking a proper hands-on assessment. Is that also agreed?

WITNESS EVENS: Yes.

WITNESS MAZUR: Yes.

SULLIVAN: And that is never an appropriate course?

WITNESS EVENS: Yes.

WITNESS MAZUR: I mean there are, there are some - I'll just put a slight - you know, I mean there are some injuries that are obviously completely incompatible with life--

SULLIVAN: Yes, but those--

WITNESS MAZUR: --from a distance.

SULLIVAN: But those type of injuries are not apt in this scenario?

WITNESS EVENS: They're not appropriate in this particular scenario.

SULLIVAN: There was a tendency of paramedics, understandably, to treat immediately as opposed to undertaking the proper triage sort process, is that agreed?

WITNESS EVENS: Yes. I, I don't think triage sort, that being a term to describe a type of triage activity. There - and there are - there is a blurring of lines naturally between undertaking a rapid triage assessment, which must be combined with the provision of lifesaving interventions. So there is a reasonable expectation that a paramedic, if they found catastrophic bleeding that could be managed with a torniquet, that they would stop and apply the torniquet and then move on.

The - I don't want to speak for Dr Mazur, but I think the - when we describe the tendency of paramedics to stop and treat, which is a globally described

challenge, it is being clear on where is the line beyond you have done initial temporising but not complete treatment, to you have now engaged in ongoing treatment and are therefore not able to complete the triage task that is your primary task now.

SULLIVAN: Right. Dr Mazur?

WITNESS MAZUR: No, I'll, I'll agree with, agree with that completely. It, it's - we all know these situations are difficult and, and "difficult" doesn't even begin to sort of describe it. But all of us who work in health, you start and then you, you - "Just this, just this, just this", and then before you know it, you, you, you - because, because we, we can't walk away from our patients, it's really hard. But, but these kind of situations demand that we do that at some point for the greater good, but, but it's a huge amount of cognitive dissonance for the, for the people engaged.

SULLIVAN: We're about to come to what may be the answer to some of these difficulties, but the final issue was that there was a re-triaging of patients because of the absence of the SMART Tags which caused further delay in some teams' movement?

WITNESS MAZUR: Yeah, that--

WITNESS EVENS: Yes.

WITNESS MAZUR: --that, that seemed to be evident in some of the statements, yes.

SULLIVAN: Let's move to the potential introduction of the Ten Second Triage tool as some way to ameliorate the problems that you have identified, but I'd like first, if we could go to Dr Cowburn to just explain the provenance, please, of the Ten Second Triage tool, how it came about and how it works. We'll bring up on the screen the diagrammatic representation, that's at page 50 of your first report at tab 22. We understand it was officially released in April 2023, but if you could just tell us, Dr Cowburn, about the provenance of this tool?

WITNESS COWBURN: Thank you. So historically, triage of patients in the UK was only ever done by health resources, so that means it's only when you've got sufficient resources on scene from the ambulance service or a healthcare provider that triage would be delivered, and it would usually be delivered in pairs.

I was part of a working group set up by Professor Chris Moran to review the triage tools that we had existent within the UK which was the NASMeD/NARU triage sieve followed by triage sort, and this was a working group which had a lot of esteemed people on it, military and civilian, academics and pre-hospital practitioners, and we were in the process of developing what then became the major incident triage tool and that was very scientifically based.

We did something that was relatively unusual in a lot of triage tools in that we did field testing, and that field testing involved a number of mock major incidents and it highlighted some factors that many of us had always suspected: that if you were using a triage tool that involved physiological variables - by that I mean counting the rate of breathing or the pulse rate - that is an incredible cognitive load on the person that is under stress, and we found that the practitioners were unable to deliver that under, under what is relatively light stress of a mock scenario.

So myself and a number of colleagues had been working on - what we wanted was a very rapid triage tool that was - basically the term is "quick and dirty". It didn't have to be super accurate, we just wanted something very easy which, when under stress, people could rely on. We wanted it to incorporate the key lifesaving interventions, that we know what - well, we're pretty certain we know what people will succumb from in the first ten to 15 to 30 minutes of a, of an incident of whatever description, and that is bleeding and airway occlusion, so we wanted to include those.

The other thing we were very keen to incorporate was that this became something that was so simple and effective that not only healthcare responders could use it, but any responder who was in the environment of the incident could use this tool to be able to deliver care. So we - this small group of us, we created what we then termed the Ten Second Triage tool, which is meant to be very simple, very effective, rapidly deployed, and can be used by anyone with some basic first aid training. If you wish me to go through each step of it, I will very happily do so.

SULLIVAN: I would like you to do that, but in effect it operates, as you've set out in your report, as a force multiplier in the early stages of a large scale incident when the responder to patient ratio is low. So for example, at Bondi Junction, police could have used this tool to then advise the attending paramedics, who were on scene minutes later, to give them immediate situational awareness; that's how it could have operated, is that right?

WITNESS COWBURN: That is correct. That is correct. So the force multiplier, by that, we mean that any responder there can use this. Not only does it give that situational awareness to the ambulance service of the number of casualties and their priority, but in delivering this tool, you are also bringing in those early lifesaving interventions, so that the ambulance service Commander is confident that the care has been delivered that needs to be delivered.

SULLIVAN: All right, so--

WITNESS COWBURN: So if, if - sorry.

SULLIVAN: No, sorry, I interrupted, sorry.

WITNESS COWBURN: So if we just walk through this tool, the first node is: Is the patient walking? Now, most previous triage tools would have put

catastrophic haemorrhage or severe bleeding as the first priority. But if we take the example of the Manchester Arena attack with the first two British Transport Police moving into the City Room within, you know, within a minute of the blast going off, what they really need to do very quickly is get an idea of the numbers of severely injured patients. So those that are walking are generally assumed not to be that severely injured. So this is a very rapid screening of allowing responders to focus on the more severe-injured. There is also the commonsense bit in this node, that if the patient is obviously bleeding very severely or they are concerned about them, they can - you know, they can ask the patient to sit down and then they go on and triage.

The next step is severe bleeding and we changed the terminology from "catastrophic haemorrhage", which is often thought to be blood spurting, to "severe bleeding" because we were aware that "catastrophic haemorrhage" means different things to different people, and severe external bleeding is what we are trying to stop. So if the patient has any signs of severe external bleeding, there's the blue action diamond which tells them to apply direct pressure, apply a pressure dressing, a torniquet or wound packing. And this very much depends on the skill level and equipment that the responder is carrying. And if severe bleeding is present, they are marked as a priority 1, the highest priority patient.

If no severe bleeding is present, you then move on to the next decision node which is: Is the patient talking? Now this is a fairly easy thing for any responder to, to understand. If the patient is talking, they do a very rapid check for any penetrating wounds to the torso. So what we are trying to pick up here is those patients that may have internal bleeding from some penetrating wound, be it bullet, shrapnel, bladed weapon, which could be causing internal bleeding.

So the areas where that is most likely to occur are the chest, the abdomen, around the pelvis, across the back, but also the areas that we call junctional areas. Now these are areas where there may be, they're kind of joined between the limbs and the body, and these are areas where there can be a lot of severe internal bleeding, so that would be the neck, the armpits, the groin and the buttocks. So this is, this is not a detailed check, it's just a very rudimentary lift the shirt up and have a look around. If there is a penetrating injury in there, we are concerned that there may be internal bleeding and therefore the patient also gets a priority 1 assigned to them. If there is no penetrating injury in these areas, they are given a priority 2 and a yellow band.

If, in the talking bit, if the patient is not talking, the next one is: Are they breathing? So it's just a simple airway manoeuvre, so a head tilt or a chin lift or a jaw thrust, which is all basic first aid. And if the patient is breathing, they are rolled into the recovery position and they are given a P1 priority. If the patient is not breathing, we still place them into the recovery position and we give them a tag which says, "Silver, not breathing." Now in previous triage tools, these patients would have been declared dead if they were not breathing with an open airway, but that is a very quick decision to make under a lot of stress, and it felt inappropriate to us that we were putting our responders under

that level of pressure to make that decision so quickly.

We also know that if the incident perhaps isn't that large and there are only perhaps one or two patients that are not breathing but a large number of responders, it would also allow the chance of resuscitation to be given if it was felt appropriate. The other benefit of not making patients dead at this stage is that this allowed, legally within the United Kingdom, for this tool to be used by any other responder, not just healthcare professionals. So it meant that no-one was going to - no patient would inadvertently be declared deceased when that perhaps would not be appropriate; they would always be left in the recovery position, and if there were bystanders delivering resuscitation, we would not stop them at that time.

So this was created and we went through a few iterations and we did a field test with responders from police, Fire and ambulance of different experience and grades, to see how quickly this could be delivered, to see the time it takes to triage each patient, and the time to lifesaving interventions. But we also involved behavioural psychologists to gain qualitative feedback about how the responders felt this tool behaved. Did it give them confidence? Did they feel enabled to deliver care?

SULLIVAN: What was the outcome?

WITNESS COWBURN: So we, we did a comparison. The first of our field tests was a comparison with the major incident triage tool that we had created and we found that - we, we set up a mock scenario, we had police and Fire Rescue there, and said, "Do what you would normally do." So if they were trained in haemorrhage control, they could do it. And then ambulance went around and used the major incident triage tool and it took quite a long time. On, on average, it took about 45 seconds per patient triaged, and the time to the last lifesaving intervention in the scenario that we had was just over 20 minutes. We - that was our control round.

We then reset the scenario and we trained all the responders in the Ten Second Triage tool and then we ran different waves through of police, Fire and ambulance. What we found, that the, the time to lifesaving interventions on the last patient went from 20 minutes to six minutes. And I think when we are talking about opening the airway or stopping bleeding, that is very likely to be the difference between a positive outcome and a negative outcome. We found that the average time to triage each patient was 10.2 seconds. We created the title "Ten Second Triage" just as a kind of rather an advertising jingle idea to, to reinforce the, the speed we wanted it done at, but it turned out to be rather serendipitously correct in the time it takes on average to triage a patient. Thank you.

SULLIVAN: You make the point that it's actually possible to triage someone in less than ten seconds if, for example, you're just at the first decision node of they're walking?

WITNESS COWBURN: Yes. So, the 10.2 seconds was the average time for

all the patients. So, a walking patient that no-one is concerned about is triaged in a split second. A patient who is talking and you need to do the check for penetrating injury, that may take ten seconds to deliver that. Similarly, a patient who is severely bleeding, the triage will be very quick. You will have made the decision they are a P1 very soon, very soon after arriving at the patient. But it may take you longer to actually apply the lifesaving interventions of stopping that bleeding.

So, whilst, you know, no patient - you shouldn't stop at ten seconds, you should carry on until the lifesaving interventions are done. But on average, when looking at a large number of patients - and we had 40 odd patients in our field test - it takes on average ten seconds per patient to triage.

SULLIVAN: After the TST has done its work in terms of that initial triage, do you then move to the major incident triage tool for a more in-depth clinical assessment; is that how the model works?

WITNESS COWBURN: That, that is one option to use. We have found what is probably the most effective way to deliver this is, after Ten Second Triage has been delivered by whichever responders, is to get a senior clinician to review those high priority patients, the P1 patients, and find the highest priority of P1. I, I colloquially call it the P1-iest of P1s. You want to find that really sick patient that needs to be given more aggressive care and transported to definitive care very rapidly.

So after Ten Second Triage is done, senior clinicians getting involved in reviewing the P1s, moving those towards a collection point and then onto definitive care, you need to get a clinician to go around the silver not breathing and decide whether they are deceased or not. But there is no pressure on them now, because they know everyone has been triaged. It allows them to take a proper thoughtful decision about whether this patient is deceased, and also you need to ensure that those P2s and P3s get some clinical attention to make sure they are not harbouring any occult injuries.

So, the major incident triage tool may be used afterwards, but in general, we find senior clinician discretion is the most effective tool, the most effective way of reprioritising those patients, only after Ten Second Triage has been completed and the lifesaving interventions have been delivered.

SULLIVAN: In terms of the rollout of the TST, it was rolled out in 2024, that's right?

WITNESS COWBURN: That's correct. So, there was a degree of overlap with when we were developing this tool and when the - Sir John Saunders was hearing the evidence of the Manchester Arena Inquiry. And when myself and my colleague, Dr Claire Park, who were both involved in the development of Ten Second Triage, we gave evidence in the January to the inquiry, and we were in - we'd just started to - we'd got the first idea of what Ten Second Triage would look like and we presented that to the inquiry team there. And I kept Sir John Saunders informed about how the development went and the

field testing that was undertaken and wrote several more reports.

And we were honoured that he placed it as a recommendation for all emergency services. In volume 2.2 he said that he felt if all emergency services adopted the Ten Second Triage tool, it may well save lives in the future. And there was certainly one patient, John Atkinson, who may well have survived had the Ten Second Triage tool been used at Manchester Arena on that tragic night.

This gave us a great impetus to gain engagement with the other emergency services in the UK, particularly police and Fire Rescue, but also search and rescue organisations, Lifeboat - all emergency services - and the voluntary aid societies. We presented the tool to them, and it was overwhelmingly well received. The qualitative feedback we had from the field test had been very supportive. And so, the roll out commenced. And obviously it takes a while to go through the training and education to get every responder in the UK, but that has now been accomplished and it's pretty much embedded within each emergency - every emergency service in the UK now.

SULLIVAN: It was tested in July 2024 with the Southport stabbing incident, is that right?

WITNESS COWBURN: It was. It was used there. I have to be cautious how much information I, I give on that, because that is still - that is now subject to a public inquiry within the UK. But suffice to say, it was used, and it was used very effectively. Unfortunately, rather like the tragedy at Bondi Junction, you know, with a bladed weapon attack, many of the patients are P1, either through severe bleeding or penetrating torso injury, or sadly they are silver not breathing. But it did prove very effective, and the patients were triaged very rapidly.

It's been used on a number of incidents within the UK, but, you know, thankfully we have not had a massive major incident with true mass casualties in the UK since it has been created. So, we don't know how it will fare on one of those, but we know it has worked extremely effectively at smaller scale incidents.

There was, there was one I was involved with not long after we had delivered the first phase of the rollout where a large road traffic collision involving multiple vehicles occurred, and a police public order unit were first on scene and they had triaged all the patients involved before the first ambulance resource arrived. Which just shows how quickly it can be delivered.

SULLIVAN: Just to wrap up that aspect before I ask one further question of Dr Mazur and Dr Evens in terms of the implementation of TST in New South Wales, or potential implementation, how do you say, Dr Cowburn, that the TST might have operated in the Bondi Junction scenario?

WITNESS COWBURN: I think if the Ten Second Triage had been embedded within both New South Wales Ambulance and New South Wales Police Force,

we would - the first ambulance response within there would have had confidence that people were being prioritised and lifesaving interventions were being delivered. The communication back to them from the police who were there in significant numbers to say how many P1s, silvers that they had in each area would have significantly improved the situational awareness, and that would have allowed the direction of incoming health care resources to be focused on the P1s to find the highest priority amongst those. And also, it would have enabled those that had been marked as silver not breathing to be reviewed in due course without, without taking responders from those that were definitely salvageable.

SULLIVAN: Thank you. Just one final matter in that respect. You and your colleagues determined to make access to the Ten Second Triage tool open because of the moral benefit?

WITNESS COWBURN: Yes. We, we felt that this was something that was just there for the benefit of patients, so NHS England put it as an open access on their website. We've presented our findings at conferences throughout the world, and we are - we're very happy for anyone that wants to take this tool and, and use it for the benefit of others to, to please feel free and use it.

SULLIVAN: Dr Mazur is the one who identified the potential utility of it. How did you become aware of the tool, Dr Mazur?

WITNESS MAZUR: It's a - we were talking before - it's a bit of a small world that we inhabit, and Dr Claire Park, who is Phil's offsider, I actually worked with her. We worked on the London Air Ambulance at the same time, and she's a very dynamic individual and I'm always interested in what she's up to and what's she doing.

So, I had been aware of it occurring, and I'd just done a little bit of reading around it. I wasn't extraordinarily familiar with it, but I was aware that - and I do know from exercises and from other roles that the current triage system, whilst works okay, even in exercises it kind of works okay, but under pressure, it does tend to not work as well as you'd like. And so I was intrigued to have seen that this tool was being - and I wasn't quite of the implementation process, but I was aware that it had been rolled out in the UK relatively recently, so I thought it was definitely something that was worth looking at, given my previous experience of the current triage tools not being as fit for purpose as we'd like them to be.

SULLIVAN: Dr Evens, you make the important point that a key component of the benefit of this tool is that all emergency services could utilise it. Could you just speak to your views in that regard?

WITNESS EVENS: Thank you. I very much think that that is a benefit. I would note that a transition from our current triage system, whereby clinicians undertake triage using the sieve and sort model, which although is a model used across the world, has been in existence for some time and has significant constraints with regards to applicability and I think time, as Dr Cowburn has

illustrated, to a Ten Second Triage model involving all emergency services, that is not a small thing. It's actually quite a fundamental change in the way that all the emergency services undertake their activity and understand their obligations.

I just reiterate the purpose of initial triage, which is to place in the hands of a person who is distributing limited resources the best approximate information about the location and urgency of the patients, again across a scene where they may not be able to see where they all are. A key benefit I see here - and I'm reflecting on the body-worn footage, body-worn camera footage I watched of the police officers caring for Mr Tahir - was that it gives the people who are with the patient, if it is a police officer who is trained in use of the tool, and - or a Fire officer who is trained in the use of the tool, or emergency - other emergency service worker, it gives them the language to express to the person distributing the resources the need that they see in front of them, and I think also gives them the confidence, when combined with JESIP principles, that that information is being expressed in a way that is more likely to result in them receiving the support that they need.

The other benefit - and again why this is not a small thing - is because it includes the provision of lifesaving interventions. And I think, as Dr Cowburn has said, there is a small menu of lifesaving interventions which are not technically difficult which are relevant to a reasonably large proportion of the patients who are affected in incidents such as this, where it may be an intervention that prevents them from dying, but whereby the time that it is applied is a significant factor to whether it is effective.

And I would include in that also first aid provided by members of the public, and whether that is supported on the telephone or through their previous experience or any training that they may have had. And an important part of this change - and as an ambulance clinician I very much support this view - is that ambulance does not have the monopoly on the provision of clinical care to patients who are suffering extreme injury in the first parts of a major incident. And the patient also does not care who did it.

But to institute that is not, again, a small thing, because it requires a level of training and of confidence from the emergency services workers who are trained, and also a consideration of what equipment they should have. And that is not a simple discussion, I do not suggest, and that there are simple answers to that question.

But collectively, as Dr Cowburn has described it, the Ten Second Triage package I think would have a significant impact on the capability of the New South Wales Government's response to patients in an incident such as this, as manifested across all of its capabilities. And the training within Dr Cowburn's report I think is important to appreciate. There was a question that we were asked to consider about the cutting of clothing to establish whether there is extensive bleeding, and that is not something that is in the normal practice of other emergency services workers, but is clearly something that training is needed to support in order to apply the Ten Second Triage tool.

And I imagine that is in part why evaluating for bleeding might take at the higher end of that timescale.

And also testing. And I also was a colleague of Colonel Park, and I think one of the challenges we identified in how we test our responses in major incidents is that we often assess was the plan completed, not was the plan effective. And one of the biggest challenges is that you can, in an exercise, correctly triage every patient, but do it at a time where some of them may not have survived. And therefore the testing that we have heard being described in the UK is important, and if this was to be a strategy that was followed in New South Wales, it would need to be supported again by an assurance process that provided us confidence that it was going to be effective.

SULLIVAN: And across all emergency services?

WITNESS EVENS: Across all emergency services.

SULLIVAN: That's clear. And ideally embedded in a JESIP-style doctrine as to interoperable working?

WITNESS EVENS: Yes, it would not be effective without the adoption of interoperability principles.

SULLIVAN: Your Honour, is that a convenient time?

HER HONOUR: We'll take the morning adjournment now and we'll resume at 12 o'clock.

WITNESS EVENS: Thank you.

SHORT ADJOURNMENT

HER HONOUR: Ms Sullivan.

SULLIVAN: Thank you, your Honour. The next issue I want to turn to is that topic of the Special Operation Team issues that were identified in your report, Dr Mazur. In particular paragraph 202, you say this:

> "Based on an assessment of what transpired, that the availability of adequate SOT" - that is, Special Operations Team - "paramedic resources on a day-to-day basis needs to be reviewed, and the ready availability of ballistic PPE for New South Wales Ambulance SOT needs to be considered".

The panel addressed these matters in the pre-conclave meeting and formed the views that are set out on pages 5 and 6 of the table. But in short form, can I summarise it in these terms. There's a clear need for a review of SOT rostering - that is, Special Operations Team rostering - to ensure that there are adequate SOT resources available in the event of another major incident like this? Do you agree, Dr Evens, or Dr Mazur?

WITNESS MAZUR: I'll let, I'll let Tom correct me, but not specifically per se. If you have - and it's up to - really up to New South Wales Ambulance to look at that mixture of resourcing and availability and expertise. So if you want to have a resource capable of managing this kind of incident freely available every day, I'm not sure that's achievable. But you need to have a process whereby, or a risk benefit of the amount of resources available can meet most of the problems most of the time, and we can upscale as required.

SULLIVAN: Dr Evens, do you agree with that?

WITNESS EVENS: I do agree with that. There is complexity to the question and a relatively sophisticated response is required. The underpinning principle that the risk should be considered, appreciated, and the response should be commensurate to the risk, and also to the requirements - within a special operations environment - that the other roles of special operations are also able to be met, and that the training and currency is also able to be provided.

When I say a more sophisticated approach I think is necessary, the underpinning principle is that access to the patients in areas of higher risk requires us to match the resource effectively to the risk, which further requires us to have an understanding of the risk as it actually is. And there are patients in some circumstances where a ballistic-trained clinician is the only clinician that can access that patient, and therefore systems have to consider the probability of that and how that can be done.

But I would not say that the most effective response is purely to lean on the provision of special operations as the only way to access patients. And much of the discussion about joint operating and the - particularly the component of joint operating principles whereby emergency services collectively understand and as far as possible reduce risk to allow access to patients rapidly and with an appropriate and shared understanding of the risk means that in most circumstances, we should be considering how can standard clinical resources access patients, what can be done to either define the areas of high risk or reduce the areas of risk. But I do accept that there are circumstances where ballistic-trained clinicians may be the only clinicians that can access those patients.

There also needs to be a consideration of whether patients can be extricated quickly. Our experience - my experience in the UK - and again I will defer to Dr Cowburn - is the equivalent of Special Operations, which is called HART - Hazardous Area Response Team, or Rescue Team - it has been very difficult to find the appropriate level of provision that makes good use of those resources and also allows those resources to be present quickly where they are required. And when I think of that in the circumstance of New South Wales, the situation again is different in metropolitan Sydney versus a shopping centre in Newcastle or Port Macquarie or Dubbo, and therefore, as was previously discussed, the joint operating principles need to consider how risk will be assessed and managed in all circumstances.

SULLIVAN: The threat environment in the UK has historically been greater than we find in Australia; that's also a consideration?

WITNESS EVENS: That is a consideration, and I think that is true. I think it's incumbent on emergency services to consider risks that are extant, but also where there may be a baseline level of risk in the future. And what I mean by that is that there are world circumstances that change the risk of, for example, terrorism attacks. And some of those circumstances were I'm sure in many of our minds as we responded on 13 April 2024. And those circumstances were different to the circumstances in 2017, and we don't know what will be in the future, but the way a system prepares has to be slightly agnostic to that level of risk. But if I think about the awful attack in Christchurch, that was a radicalised individual that maybe represents the baseline level of risk, and emergency services must consider that as well.

SULLIVAN: So, it's a complex question in terms of the availability of Special Operations Teams to deal with that scenario, one that the New South Wales Ambulance Service needs to anticipate in its resourcing, but difficult to do that perfectly. Is that a fair summation?

WITNESS EVENS: Yes, yes.

SULLIVAN: Dr Cowburn, do you have a comment?

WITNESS COWBURN: Thank you. I would again very much agree with Dr Evens' view. This needs to be based on your risk, and you need to work out what these teams are going to be doing, what training they need. And it's very pertinent that he mentions the Hazardous Area Response Teams, which are the UK equivalent. They are a national interoperable asset that is meant to be mutual aid across the entire country for large scale incidents. We are currently undertaking a very high-level strategic review about what we want those teams to do, because we realise that our system of having multiple teams across the country at a high state of readiness immediately deployed and trained in multiple domains of activity is expensive, and we need to get maximum patient benefit.

I completely agree with the idea that what we don't want to do is rely on a small number of highly trained individuals to be the only source of delivering care. We need to make the system flexible and agile with a mature opinion around risk to ensure that the patients are getting the care that they deserve.

My only other additional thought around this is the immediate deployment of those individuals at the point that this type of incident is noted. And it is very similar to the findings we had within the Manchester Arena Inquiry. When I read the timeline and the transcript of the activity from the first calls that were going into New South Wales Ambulance, this had all the hallmarks of an active armed offender attack, and in the UK, that would have had immediate alert to our Hazardous Area Response Team and a deployment. Whereas reading through, it seems that the response from SOT was slightly staggered and perhaps not as well organised as it could have been in the immediate

response to very valid intelligence from the first callers that this was an, an AAO incident. Thank you.

SULLIVAN: Both the panellists are nodding. Dr Evens and Dr Mazur are nodding in agreement with those comments?

WITNESS MAZUR: Yes. If you look at the statements, it seems that the AAO work instruction or policy wasn't adhered to in this event, and it was - there was a, there was a degree of fortuitousness that SOT were tasked when they were.

SULLIVAN: Dr Evens?

WITNESS EVENS: Yes, I would agree that there is value in predetermined responses within major incident plans, and that's something that sits in control rooms and that's something to consider in the rewrite of AMPLAN. And, and I guess I, I just note that the timescale within which actions are effective in this kind of incident do not allow for the slow gathering of what is sometimes a remote resource.

Now, there are other circumstances where incidents are more prolonged. There have been circumstances overseas where there has been siege situations where ballistically-trained clinicians can be very much appropriate. But at Westminster Bridge, at London Bridge, all patients had been cleared from the scene prior to the arrival of those resources, even though those resources were tasked very quickly. And so our posture needs to be sophisticated, and again I just reference that joint operating and therefore understanding of risk and therefore facilitation of access of any clinical resource is likely to have a greater impact on a situation such as this.

SULLIVAN: You make the point in the context of the discussion - this is noted - that there's an active role for police in enabling clinical staff to access patients commensurate to the threat, and that police presence can mitigate threat. So that's also a factor that you're referring to, the essential role of police and that interagency working in enabling access to patients and extrication of patients?

WITNESS EVENS: Yes, I think the police can be very valuable in changing the risk to a clinician, and therefore changing the decision to deploy a clinician into a space.

SULLIVAN: Let's go to a less--

WITNESS MAZUR: To, to a - sorry.

SULLIVAN: Please.

WITNESS MAZUR: To a degree that was demonstrated I think at Bondi with the initial entrance of Inspector Simpson and his team, because he spoke to police, spoke to security, went with them, or instructed them to come with him. And so to a degree demonstrated that at this - in this incident.

SULLIVAN: Yes, thank you. A less complex component of the SOT response perhaps, can we all agree that there's some urgency around the need for sourcing of PPE, ballistic PPE, for the SOT officers who are deploying? That is, ideally they will have access to PPE in their vehicle for any given shift?

WITNESS EVENS: Yes.

SULLIVAN: Agreed?

WITNESS MAZUR: Yeah, it doesn't make sense to have a resource that requires that PPE and for that PPE not to be with them.

SULLIVAN: Do you agree with that, Dr Cowburn?

WITNESS COWBURN: I do indeed, yes.

SULLIVAN: And that's an urgent situation to resolve?

WITNESS COWBURN: Yes.

SULLIVAN: Dr Mazur?

WITNESS MAZUR: Yes.

SULLIVAN: We're changing topic now. We're going to the related topic of the hot zone issue. You're all well familiar with the chronology, but perhaps the most pointed example of that chronology in terms of the hot zone declaration is we know that a Chief Inspector broadcast a message to VKG - that's the police radio - from the CCTV control room at 4.27pm confirming one offender only and nine victims. And then a minute later at 4.28pm, the Assistant Commissioner's declaration as to a hot zone and the requirement for all paramedics to leave Westfield was issued by another Inspector over the ambulance radio.

SPEAKER: Just to be clear, that Assistant Commissioner from Ambulance.

SULLIVAN: From New South Wales Ambulance, Assistant Commissioner Armitage gives the hot zone declaration. And we know that that hot zone declaration was in fact never downgraded; that was Assistant Commissioner Armitage's evidence. He agreed that it should have occurred sometime after 5pm when he attended the joint command post with police and obtained that information, to the effect that there was one offender only and no further threat. So that's the scenario.

Dr Cowburn writes in his second report:

> "This hot zone declaration had the potential to cause further lives to be lost and harm to be caused. It was fortuitous that no further salvageable patients remained within the scene when this decision

occurs."

And he goes on to say, "This should be considered a near miss, and it's essential that this learning is incorporated into future interoperable responses to prevent future deaths." Do you agree with that sentiment, Dr Mazur, first?

WITNESS MAZUR: I do. Can I say that I have some sympathy for Inspector Armitage, because no leader wants their people - I may not use those words right - to, to come to harm. And so he was acting on information that he had to keep ambulance personnel safe.

SULLIVAN: And that's understood.

WITNESS MAZUR: The, the problem of course was that the information was flawed and, and wasn't available in, in a timely manner. And that comes back to the interoperability, and that communication across all emergency services. So if, if it had been - and both - and I think Inspector Simpson got similar "off" information earlier on as well.

SULLIVAN: He did, yes, at 4.01pm.

WITNESS MAZUR: And so, they acted on the, on the best principles of the available information they had; it's just that the way the information got to them and the information itself was flawed, and that's the part that, that needs to try and be--

SULLIVAN: That's understood.

WITNESS MAZUR: --resolved.

SULLIVAN: Yes. Dr Evens?

WITNESS EVENS: I agree. Any situation where a Commander makes a decision based on information which is not correct, that then results in a limitation of access to care when the true risk would have allowed access to care, does represent a near miss, and is therefore an important learning opportunity.

SULLIVAN: Can I suggest to the panel that it's hard to conceive of a better example, in terms of silos, than this scenario? Do you agree Dr Evens?

WITNESS EVENS: I agree.

HER HONOUR: Dr Mazur?

WITNESS MAZUR: Yes that's what I - I think that's what I stated in the report--

SULLIVAN: And Dr Cowburn? Yes?

WITNESS COWBURN: I agree.

SULLIVAN: All right, so against that backdrop - this is the context in which we consider JESIP - we'll come to that - but in particular the issue of zoning. You say at page 38 to 39 of your report, Dr Cowburn, that the issue of lack of information sharing and communication resulted in impaired shared information awareness. That's in connection with this hot zone issue, but this was a similar scenario we understand to what happened in the Manchester Arena Inquiry, is that right?

WITNESS COWBURN: There are definite similarities. And I, I'm, I'm going to preface this with I completely agree with Dr Mazur's thoughts. It is a very difficult decision when you are the Commander, because you are balancing the risk to patients coming to harm from a delayed response - what we've, we've termed in the Manchester Arena Inquiry "the care doubt", when responders are not there - versus the risk to those under your command that you may be putting into harm's way. And therefore, a lot of these decisions need to be a very dynamic risk assessment.

Within Manchester, there was the - there was a perceived hot zone due to the threat of a second improvised explosive device, which is always a risk, but at that time there were bystanders and unprotected police officers delivering care within the City Room. And there were protected responders held outside at the risk of harm because people felt that it was a hot zone.

I will - I am not a, I am not a fan of the terms "hot", "warm" and "cold zone". I think they become very dogmatically followed. I think it needs to be a very dynamic risk assessment based on the information that is shared between all emergency services as to what that risk is, what mitigation can be put into place, and the view that the saving of lives and the reducing of harm is the essential component.

Subsequent to both the Manchester Arena attack and the London Bridge Borough Market attack, we have changed the way we approach zoning within our UK MTA response, so the equivalent of the AOO - AAO in Australasia, whereby we say the default is that unless there is robust evidence of a threat, responders will deploy forward to save lives, and that zoning is not mandated at these incidents, and that the zone, if it is put in, needs to be as small as possible so that patients can have care delivered to them.

My cautions around zoning is having reviewed a number of real incidents and numerous exercises on this, the zones are always put on too big, and they are left in place for too long and patients come to harm as a result. Thank you.

SULLIVAN: Thank you, and that's the matter you refer to at page 49 of your second report where you say:

> 'The dogmatic and prescriptive application of zoning has been shown to result in detrimental outcomes to patients at numerous exercises within the UK, therefore I would advocate for a more agile, flexible approach based on tangible risks so that patient care is

maximised and responder risk is minimised."

That's what you're referring to?

WITNESS COWBURN: That is indeed.

SULLIVAN: Dr Evens do you have a comment in relation to that?

WITNESS EVENS: I do. In, in broad terms, this is a complex discussion about risk and exposure to risk of emergency services workers.

SULLIVAN: Yes.

WITNESS EVENS: Which has to reflect the views of society, and it is important I think to note that some of the UK evolution has been led at a political level which leaders require to understand what is the appetite of society to expose emergency services workers to risk. And that leads to a, a second point, which is that to be a Commander in that circumstance is an invidious position, because information is not certain, and there are many cases in the literature where Commanders have made decisions to expose their staff to risk and their staff have come to harm. And that is part of certainly the UK Tactical Commander training, and that is always in our minds. And the information is not clear, and the natural question that people ask, and that was asked at Bondi, is, "Is the scene safe?" And the challenge here, and the challenge with zones, is who can tell you that?

SULLIVAN: Yes.

WITNESS EVENS: And the answer is no-one can tell you that the scene is safe, but what they can tell you is, "Here is the known risk, and here is the known information." And it is most important to place the Commanders who are making those decisions firstly in a context where they know what the expectations are, what society's expectations are, and I know that sounds very nebulous but I think that's, that's actually really important. To ask an individual to do that without that knowledge is, is, is not fair. And also where they know the best information that they can know, and that they know they're operating in a culture where the experience after the fact, I think as has been experienced here, I want to acknowledge that, has been one where their position and the uncertainty of their position is understood by those who would judge them afterwards.

SULLIVAN: Yes.

WITNESS EVENS: And those three things are all important here.

SULLIVAN: Yes. Dr Mazur.

WITNESS MAZUR: No, I, I couldn't agree more. We, we, we - from, from the very start of anyone's career in a pre-hospital environment, that the first rule of the first thing that we always have to consider is safety, you know, personal

safety, scene safety and then survivors. And that, that is, that is drummed into us from day 1. I, I, I examine for the College on a, a - in this topic and, and that's almost a, a bold point in any exam that occurs, "Have they addressed safety?" Now, now complete safety can never be guaranteed. So as my colleagues have said, there's always that risk assessment. How safe is safe? Is this safe enough? And for - and society will vary on what they, what they - as Tom has said, as to what level of safety is prepared to risk. And some people in our jobs will be prepared to, to maybe accept slightly less safety than the rest of society--

SULLIVAN: The risk appetite.

WITNESS MAZUR: Whereas, people in other positions, their safety has to be higher. And that's, and that's how we select the roles that we do. So absolute safety can never be guaranteed, and absolute safety will result in patient harm. But, but there's a, there's a fine balance and there's a trade-off. And that's what Commanders and clinicians have to ascertain as part of their dynamic risk assessment--

SULLIVAN: In making that assessment, they need to have the best quality information available, agreed?

WITNESS MAZUR: That's how you make the best decision.

SULLIVAN: And that information may come from a variety of sources, but in particular your emergency responder colleagues. That's right?

WITNESS EVENS: That's right. From the public. And there is a, there is an information fog I guess in the - in this situation, whereby information might come to any one of the emergency control rooms. It's not the role of the public to know which one to ring.

SULLIVAN: Yes.

WITNESS EVENS: The information may be described incompletely. Sometimes information that comes to the control room says that "I have heard something". And actually what has been heard has been, for example, the police response. And assimilating that information across multiple control rooms, if there are multiple incidents and multiple sites, that is very difficult and certainly not something that someone on scene can do. And then when that information is held by different emergency services, again unless that information is pushed to the people who are making that risk assessment then they do not have the best information in front of them, and that is where the near miss I think occurs.

SULLIVAN: I think we've now naturally landed in the place of JESIP. The discussion on not necessarily the wholesale application of the JESIP doctrine to be clear, but picking up the parts of it that may have particular application and may be of benefit to New South Wales. We've touched on it already because her Honour astutely pointed out that I was throwing the acronym

around rather loosely without an explanation of what it is, but in short, can I just ask that we bring up please the Pollock report? This is in the reference material that was provided to Dr Cowburn's second report.

This is a report that was prepared in 2013 by Dr Kevin Pollock, and it was a review of persistent lessons identified relating to interoperability from emergencies and major incidents since 1986. So it incorporated all the learnings in one place. You're familiar with this Dr Evens? This--

WITNESS EVENS: I, I've not read this article, no.

SULLIVAN: It was an attempt, a valiant attempt to distil some of the key lessons that seemed to be identified but then not put into practice in terms of interagency workings. It looked at 32 major incidents within the UK, including the Lockerbie bombing in 1988, the Hillsborough Stadium disaster in 1989 and the London terrorist attacks in 2005, amongst others. And the findings are very briefly summarised with some elegancy in two pages. If we could just scroll through please to page 6, and you'll see there the research findings:

> "The common causes of failures identified within the reports and relevant to interoperability includes poor working practices and organisational planning, inadequate training, ineffective communication, no system to ensure that lessons were learns and staff taught, lack of leadership, absence of no-blame culture, failure to learn lessons, no monitoring audit mechanism, previous lessons reports not acted upon."

Do you agree that those principles are often seen in connection with major incident reviews in your collective experience?

WITNESS COWBURN: Yes.

WITNESS MAZUR: Particularly around communication. If, if, if you - I, I think from all, all the literature that I've read and reviews, if you were to pick one topic that would come up in just about every incident, it would be around communication.

SULLIVAN: Okay. So it goes on then to identify the four main aspects that are relevant to JESIP and the strategic issues distilled to doctrine:

> "Provision of clear and easily understood guidance that ensures everyone is aware of their own and others' responsibilities and roles; operational communications, the need for a common system used by all stakeholders with the capacity to deal with surges of capacity associated with major incidents; situational awareness, the ability to quickly access and share information between stakeholders; and then training and exercising, the need for continuous development of stakeholders to ensure sufficient capacity to cope with a prolonged event."

And it goes on to identify the JESIP framework. And then under "Conclusion", just this last point I draw to your attention, the first paragraph:

> "The consistency with which the same or similar issues have been raised by each of the inquiries is a cause for concern. It suggests that lessons identified from the events are not being learned, to the extent that there is sufficient change in both policy and practice, to prevent their repetition."

Is that a message that you think we should particularly heed as we sit here taking this evidence today?

WITNESS EVENS: I very much agree with that, and I note that that was written in 2013 and we actually had to continue learning the same lessons. There is no reason not to benefit from all of the learning that exists already for us in New South Wales as we consider what we do now.

SULLIVAN: Do you agree, Dr Mazur?

WITNESS MAZUR: Yeah, 100%.

SULLIVAN: Dr Cowburn, we've lost you behind the Pollock report. There you are. Thank you.

WITNESS COWBURN: I - a very honourable place to be lost behind, Kevin Pollock's report, in it is a very powerful message. And I agree with Dr Evens, despite that, we are still having to address many of those aspects. And this is not a quick fix, this requires commitment from all those involved to work together to improve things and keep learning from every exercise and every incident, it's an organic ongoing process, not a quick fix.

SULLIVAN: JESIP is in some respects the beneficiary of things like the Pollock report and the inquiries that have flowed from it in terms of refinement, is that an accurate statement?

WITNESS COWBURN: Yes. You know, JESIP has evolved and will continue to evolve. It is not without its issues. And if you look at the Manchester Arena Inquiry, particularly Volume 2 Part 1, there is an extensive debate around the issues with the application of JESIP at that tragedy, and it was quite hotly debated whether JESIP was fit for purpose or whether it was the failure to apply JESIP that resulted in many of the issues that occurred.

SULLIVAN: What was the outcome?

WITNESS COWBURN: From my perspective, it was the failure to apply the five key principles that was the major issue. And for me, the co-location is the first step, it is the pivotal step. If the Commanders do not co-locate - and when at scene that means being face-to-face - then the rest of it will fall down.

SULLIVAN: Can we pause that, Dr Cowburn? I just interrupt because I'm

about to take you to the principles and get your reflections. But in short form, is this an accurate summary, that JESIP, as a doctrine, has withstood the scrutiny of a number of public inquiries. The issue has always been with its application and not the principles themselves. Is that a fair summation?

WITNESS COWBURN: I think that is a fair summation, yes.

SULLIVAN: You say on page 25 of your second in terms of the future of JESIP within the UK, that the results of particular research that you've cited, alongside the public inquiry review, have prompted a reinvestment and revision of JESIP, and in the last year a new lead has been appointed, Chief Superintendent David Boyle with an expansion of the team with clinical and educational leads from all emergency services. So there is a reinvigoration of the model, in effect, and its principles?

WITNESS COWBURN: That is correct, yes.

SULLIVAN: And evidently faith that it's an appropriate paradigm?

WITNESS COWBURN: Yes, the, the principles are sound and it, it requires, it requires dedication and work to make them effective.

SULLIVAN: We'll just bring them up quickly if we could, this is at tab 23, please, page 12, and this is the joint working principles which the previous page notes are particularly important in the early stages of an incident when clear, robust decisions needs to be taken, with minimum delay, often in a rapidly changing environment. I'll just go back to the diagram, but there are the five principles. We have the benefit of your analysis in your second report as to those you think are perhaps of particular significance, or are pivotal, I think as you describe the first principle. But can I ask you for your views please about how the JESIP principles have worked in practice in your experience?

WITNESS COWBURN: So I've, I've - having been within ambulance service leadership roles pretty much from when they were first instituted, I have seen application of the JESIP principles that has varied, and if they are, if the principles are applied well so that all the Commanders are versed in those key principles, ideally have been educated together and trained together, those five principles will lead to a more positive outcome.

SULLIVAN: You describe I think co-location as the pivotal principle?

WITNESS COWBURN: I, I think that co-location at the operational scene is the key aspect. And when I look at Manchester Arena Inquiry, the Dawn Sturgess Inquiry, and multiple other aspects of exercises and training, if that is delayed or not instigated or not maintained, that is when the, the truly, the truly effective, collaborative response will fall down. Once that is instituted, that forces people to communicate and leads to coordination, and it then is around the shared situational awareness that I think is the next most important of those principles.

The risk, sharing the information around the risk and coming to an understanding of what that risk is in the mitigation is all part of that situational awareness. And then the decision-making about what we are going - what should be done to maximise the saving of lives and the reducing of harm, if you take the work from Dr Sabrina Cohen-Hatton around the decision-making aspect, that is where the real benefit comes in, but from an, an at-scene approach, it is the co-location that is key.

SULLIVAN: That can happen in an informal way as between Commanders. For example, I think there's the reference to the "bonnet huddle".

WITNESS COWBURN: Yes.

SULLIVAN: That is, one assumes, over the bonnet of a car, the three Commanders just having that early discussion, sharing information and assessing risk to their responders and an early plan.

WITNESS COWBURN: Yes, and that can be instituted within a few moments.

SULLIVAN: In terms of co-location and communication, if we could go please to the JESIP principles page 16, and this is a point that Dr Evens has adverted to a number of times, and I was waiting for the big reveal of this part of the JESIP document that dovetails into those comments about the importance of control rooms in obtaining early situational awareness. There is no evidence in this brief as to any indication that control rooms were in contact in the way that is envisaged within page 16, that is, the importance of control rooms in developing a common operating picture as between each of the agencies individually and together. But you see there, Dr Evens, the bullet points in terms of the discussion between control rooms. Is that the type of thing that you are envisaging?

WITNESS EVENS: Yes, and at risk of repeating myself, the challenge is that these principles are easy to understand but hard to achieve. It is not correct to say that there is no communication between control rooms at the moment. And I'm aware that the Ambulance Executive Director of Clinical Operations who holds expertise in this area will be giving evidence later.

SULLIVAN: Yes.

WITNESS EVENS: There, there is communication, and in slower moving incidents, there is actually a well-established, I think very effective process in New South Wales whereby liaison staff are able to work across control rooms. And I think if one looks at incidents like the recent, near Tropical Cyclone Alfred, an incident, for example, there's very good examples of coworking across control rooms, including with the State Emergency Services and others.

The challenge is to effect that rapidly when there is limited information, and therefore using on-duty resources, which speaks to some of the training challenges and obligations that I think we face, because it's really the actions

of the person who is currently managing the control room and the day-to-day work in Sydney and the call-takers who are taking calls from across the State, and the dispatchers who are managing normal activity, to then be able to, in those first 15, 20 minutes, assimilate information and share information and have no doubt the police and the Fire control rooms would have a similar challenge, which is not to say that this is not something that is important, but it is also not simple.

SULLIVAN: No, but critical to obtaining early situational awareness in a rapidly unfolding event.

WITNESS EVENS: Early situational awareness in a rapidly unfolding event is, is, is really important, and I suppose if it comes to this question of co-location, I think one of the things we've learned is that JESIP as a principle does not work if you get there, do your stuff and then go, "Now let's do some JESIP." It needs to be in the mind of all the services as the Commanders are responding. Accepting that situations might evolve and, and, and how you co-locate may, may differ once you are there.

SULLIVAN: Thank you. Dr Mazur?

WITNESS MAZUR: The only, the only parts that I'd add to that is that, and we already recognise the difficulties, and, and the other difficulties to realise are that each organisation has slightly different or, or maybe even significantly different priorities, so, so what may be extraordinarily relevant to one organisation may be completely irrelevant to another organisation. So, so the just sharing of all the information won't - isn't what was required, so somewhere there has to be a filter or some kind of process that, that there's an acknowledgment about what information is relevant, because otherwise too much information is even worse, you're just completely overloaded.

SULLIVAN: That's a perfect segue to the METHANE diagram on page 21 of tab 23, if we could bring that up. This is, as we understand, the model, an established reporting framework that is used by all responders and control rooms to share information in the context of the JESIP model. That's right, Dr Cowburn?

WITNESS COWBURN: That is correct.

SULLIVAN: So then each organisation will send METHANE messages and share it and the common operating picture develops as that occurs. Is that what you're talking about, Dr Mazur, the need for information to be provided in a particular format that's understood by all agencies?

WITNESS MAZUR: Yeah, to a degree. The, the METHANE is a very valuable tool, it's been, it's been utilised in health services and, and ambulance services for, for a long time, comes from MIMMS principles which is where, where we sort of started, major incident planning from, and gives a shared communication framework. It, it's, in and of itself, it may not contain all the information that other organisations require as the situation develops. And in

some situations, it, it may contain stuff that's irrelevant to other organisations but it's, it's a nice starting point, it's a nice framework on which, which to build, I guess, and does allow for that shared common language if all organisations are using that tool as, as a great starting point.

SULLIVAN: Do you have a comment, Dr Evens?

WITNESS EVENS: Thank you. I think it also speaks to the other JESIP principles which is a shared understanding of the functions and tasks of the other emergency services because this principle of how to proctor and filter and then share appropriate information, particularly when the information is incomplete, can only be done if the person who is pushing information has sympathy with what the person at the other end needs, and that can't be done in the moment or retrospectively, and it comes back again I guess to just this investment in training that is required.

SULLIVAN: Thank you. Dr Cowburn, can I ask please, if you have page 37 of your second report in front of you, please, this is where you assess in effect how JESIP might have operated in the circumstances of 13 April, and I'll just read this passage of your report onto the record given its importance, you say this:

> "Both services deployed significant assets, that is New South Wales Ambulance and New South Wales Police, to the incident in a rapid manner. This is appropriate and essential to optimise outcomes for those involved".

And you go on:

> "The actions of Amy Scott were exceptionally brave and prevented additional loss of life. Following, confronting and neutralising the threat, she undertook a command role until relieved, which demonstrates exemplary composure".

And then you go on to state:

> "The early deployment into the scene of ambulance service assets effectively closed the care gap and is likely to have prevented a number of deaths that would have occurred had they not adopted a forward leaning approach. Much of this should be credited to the command decisions of Inspector Brett Simpson. The interaction between Inspector Simpson and the police present at the scene exemplified many of the JESIP's principles.
>
> There was a focus on working together to save lives. This involved co-location, communication, rapidly undertaking a dynamic risk assessment to understand the potential threat and mitigation and gaining sufficient situational awareness to coordinate forward deployment. The joint working to deliver lifesaving interventions at individual patients demonstrates effective joint working at a

grassroots level, as would be expected between emergency services who regularly respond together".

So that is an assessment of the responders on the ground, and that's an A+ rating. It's hard to conceive of that aspect going much better. But there are some learnings in terms of how JESIP might have operated at the operational and strategic levels of command?

WITNESS COWBURN: Yes.

SULLIVAN: Can I ask you to expand on that?

WITNESS COWBURN: Yes, so I - the - that first initial wave was absolutely exemplary and deserves massive commendation. I just wish that we could achieve that level of forward leaning patient focus approach in the UK more regularly.

SULLIVAN: Just pausing there, what do you mean by forward leaning?

WITNESS COWBURN: By that I mean a willingness to go in to save lives. Historically within the UK a number of incidents - and we see it in exercises - if they're balancing that risk to responders and the benefits to patients, there is a tendency to hold back awaiting more definitive information that it is absolutely safe. And that extends the care gap, and that's when lives are lost. So, I think the willingness to assess the situation, to work out that there was no immediate threat in front of them and for the New South Wales Ambulance to go forward alongside the police who were already present is what I would describe as very forward leaning. Which is to be congratulated.

SULLIVAN: I'm sorry, I was asking you about your assessment as to the aspects of JESIP that we do need to consider?

WITNESS COWBURN: Yes, and of course we are doing this with a degree of hindsight, and the retrospect of it does give a slant. As Dr Mazur has already described, the noise of the siren, the busyness of the incident, the large number of people that were moving around, the information that was coming in, much of which is likely to be conflicting, what was required there was the Commanders to co-locate. By that, I mean the Commander of the scene from the police and from the ambulance to position themselves somewhere that was visible to their colleagues. They were able to ascertain as good information, as concrete as you could get in the confusion of the situation so that they could direct their assets and share that information.

The information regarding the single offender and the fact that they were neutralised was available. It just was not shared. Now that is probably one of the key aspects that I feel could have been significantly improved in this response.

SULLIVAN: We know that there was a multiagency briefing at 5.30, and you would have read Mr Wilson's view that that was too late for a multiagency

meeting. In the JESIP model, appreciating that the Commanders are coming potentially from other parts of a metropolitan city, so they're not necessarily going to be five minutes away, how quickly would that JESIP huddle occur?

WITNESS COWBURN: So, if the JESIP principles are truly embedded at a grassroots level, you could argue that that first JESIP huddle had started to occur already, in that Inspector Simpson had already met with the police and made a decision. What, subsequently was that everybody was involved in delivering care further forward, and what was needed was a JESIP huddle on the periphery of this as more senior Commanders arrived.

Now that may mean that they hand over command or somebody steps back to maintain a command position while others go forward, and it is only through training and exercising that you can deliver that dynamic response, which, you know, you cannot write down as being dogmatic and this is the way you will do it. If that had occurred, you would have had this rolling ongoing sharing of information. And so that meeting, that first multiagency meeting at 17:30 would have been the culmination of a progression of smaller meetings that would have gained all of that information.

And so, I would not wish to criticise that that tactical meeting occurring at 17:30, that was a completely appropriate meeting, but that would have been almost the closure of the active phase of that incident, rather than the first get together of all those multiagency commanders.

SULLIVAN: Your colleagues were nodding during that. Do you agree Dr Mazur?

WITNESS MAZUR: Yes. Dr Cowburn - and again I've tried to bring that out in the report that I've put together, in that the difficulty was for the Ambulance Commander who was - or the Forward Commander who was inside and then directing care, and as Dr Cowburn's quite eloquently put, there needed to be someone on the outside able to help them with the bigger picture stuff occurring outside. And that also needed to incorporate the other emergency services that were there. And that moment, I won't say it was lost, but was definitely unfortunately delayed in this scenario.

SULLIVAN: Dr Evens?

WITNESS EVENS: Thank you. Yes, I'd highlight a couple of points. The previous position that there are JESIP principles and there are how JESIP is operationally delivered is important and has matured. And in the current version of the joint operating principles in the UK there is a very explicit position that there is a shared responsibility for the saving of lives. And I agree with Dr Cowburn's statement that that was enacted here, and it was very clear that police and ambulance inside the building felt that they had a shared responsibility to save lives and therefore that drove their actions. And that's important.

It's - I think there's - reading some of the statements, it's clear that

Brett Simpson was not reckless in this. We're not commending him in terms of being forward leaning for recklessly barging in. That he has gauged what information he can, and by necessity, I don't think he has identified a Police Commander to ask information from. He has sought information from the police who were nearby to him, and the evolution of a JESIP command structure such that actually the information is being shared by a person who one could reasonably believe is also themselves receiving information from within their own service and is therefore in a good position to share - well both to assimilate and then share relevant information is important. And I think that's an opportunity for us.

I just also note that as we went through the exercises that supported the development and the training of these principles in the UK during the period 2012 through to certainly 2019 when I was working there, we went through a period where if you were in a command position you essentially were persistently in a meeting. And it can - these principles can be read such that you are constantly meeting and not commanding. And that is why, and I think the current joint operating principles address that, but when we describe the importance of co-location in command meetings, what we're not espousing is an abrogation of the other command responsibilities.

And so having the principles clear in one's mind before you arrive, knowing that you need to assimilate and push information to the other services, and then you need to collectively agree how the Commanders are now going to go forward and meet and action their tasks. That cannot be prescribed. That has to be done by appropriately trained people in the moment.

SULLIVAN: Just briefly stemming from that, is there a role for interagency talk groups - multiagency talk groups I think they're called by Dr Cowburn in his report - do you think, Dr Evens, as an early way of establishing situational awareness as between Commanders?

WITNESS EVENS: Speaking as a physician and therefore without the technical knowledge of how the radio system works in New South Wales, I would say in principle yes, but reserving that I don't have the background to comment further.

SULLIVAN: Dr Mazur?

WITNESS MAZUR: Yes, I have the same level of technical understanding as my colleague but also would caution that - and we've brought this up already - that putting everything onto the one channel will very quickly overload the system. So, the multiagency talk group would need to be carefully thought out as to who goes on that group and at what level and what information goes on that talk group. Because if it's everyone, then it will fall over no matter how good it is. And - yes.

SULLIVAN: There are controls around that, we take it, Dr Cowburn, in terms of how it works in the UK?

WITNESS COWBURN: Yes, indeed. And my colleagues are entirely right. You don't want everybody at scene and everybody in your control rooms trying to speak over the same channel. Within the UK the multiagency talk group is usually reserved for control to control conversations and the sharing of METHANE and key pieces of information, and probably the most senior Commander at scene from each service, so that they are all sharing that situational awareness.

The agencies will have their own set of channels, which will be single service, and the ability, one of the other bits that I highlighted in my report and we discussed as a group, is the ability for the control room to push those responders who are arriving on scene onto a single agency major incident channel so that they can communicate without having to make the effort of changing onto that channel, which they may miss the communication of because of all the noise and other cognitive load. Thank you.

SULLIVAN: Thank you. If we can come now finally, please to the recommendations that you have proposed at page 49 to 50 of your second report, Dr Cowburn. That's two groups. One is to the New South Wales Government as a whole. I'll just bring that up on the screen, please, page 49.

> "The New South Wales Government should strongly consider the introduction of a joint emergency services interoperability philosophy to improve collaborative working between these agencies. This will have multiple potential benefits in incident response and patient outcomes".

Then you go on to identify the aspects of JESIP that you strongly advocate for, namely, METHANE, principles of joint working, the joint decision model, aspects of the marauding terrorist attack joint operating principles, and then the Ten Second Triage tool. Dr Mazur and Dr Evens, you've had an opportunity to consider those recommendations. Do you agree?

WITNESS EVENS: I broadly agree. The only point I would note is I think that there should be a joint decision model, which should be carefully thought through.

SULLIVAN: Yes.

WITNESS EVENS: And not necessarily the joint decision model as is. It's directly been written in these documents, and I think that just reflects lived experience, and I note that Dr Cowburn has commented that naturalistic decision-making is probably more suited to well-trained senior leaders.

SULLIVAN: So that's the asterisk that--

WITNESS EVENS: But other than that, I, I agree.

SULLIVAN: Dr Mazur?

WITNESS MAZUR: I, I would, I would say that my, my working knowledge of JESIP and these principles is less robust than my colleagues.

SULLIVAN: Yes.

WITNESS MAZUR: But, in looking at it in, in overview and in principle I would, I would agree.

SULLIVAN: The second group of recommendations relates specifically to the New South Wales Ambulance Service. That's on page 51, and there's - these really I think are incorporated in relation to the New South Wales AMPLAN document, and you see those matters there. I don't need to go through - with the exception of the Special Operations Team recommendation, which sits somewhat apart, but do you broadly support the matters set out on page 51, Dr Evens?

WITNESS EVENS: Yes I do. And I think actually the, the recommendation to review with regard to the delivery of the Special Operations Team functions, I also support.

SULLIVAN: Thank you.

WITNESS MAZUR: Yes, I, I agree as well.

SULLIVAN: Before we move on from JESIP, are there any final reflections? I only have a couple of limited matters to go. Dr Evens starting with you?

WITNESS EVENS: No.

SULLIVAN: Dr Mazur?

WITNESS MAZUR: You, you mean specific to JESIP?

SULLIVAN: Specific to JESIP and its potential application in New South Wales?

WITNESS MAZUR: No.

SULLIVAN: Dr Cowburn?

WITNESS COWBURN: Thank you. I, I think, would just to a degree reinforce what Dr Evens has said. I - the, the philosophy around JESIP is much more important than any of the detailed bits within the doctrine itself, and I share Dr Evens' concerns around the joint-decision model, particularly when it is used in a very fast-paced situation, particularly at the scene. I don't think it is agile and applicable in those situations when naturalistic models delivered by very experienced and competent Commanders are far more applicable. Thank you.

SULLIVAN: Thank you. Your Honour, I have about five to seven minutes left.

I'm happy to continue if your Honour--

HER HONOUR: We might continue I think. Thank you Ms Sullivan.

SULLIVAN: I want to turn to some potential lessons that might be taken on board by the New South Wales Police Force in terms of the delivery of first aid by police on the scene, and I caveat that topic introduction by indicating that there's no question that the attending officers did their very best and delivered effective first aid, but certainly we'll take this opportunity to provide any critique as to improvements. Can I suggest that - and this arises from your report Dr Mazur - there's a question about the utility of CPR in circumstances where you're dealing with penetrating trauma wounds, and indeed CPR can in some circumstances cause further harm? Is there some teaching that should be conveyed by police(as said) in that respect?

WITNESS MAZUR: This is a, this is a fraught issue can I say. It's, it's - there's no simple black and white answer to this. And I would like to re-emphasise that the actions I saw and read about from the police force were tremendous. What I will say is that CPR - and, and really when we're talking about CPR we're talking about chest compressions; they're often used interchangeably although they're not strictly the same thing. There can be issues around that and traumatic cardiac arrest. And by that - and generally when we're talking about traumatic cardiac arrest, patients have gone into arrest because they've, for a number of possible - often, often diluted down to four possible reasons. There's a problem with oxygenation. There's a problem with blood volume, or there's a, there's a problem with obstruction to cardiac output for some reason, so a tension pneumothorax or a tamponade.

None of those problems will be well-addressed by chest compressions. They're unlikely to fix those issues. So I guess the point I was making in my report was that whilst CPR was admirable and was in the training, was unlikely in the vast majority of the situations to improve patient outcome, without going into that. And that's primarily because the compression of a heart that's pushing against an obstruction or is under-filled won't fix the problem.

So perhaps - and it's nuanced, because in some situations of arrest, it's not due to trauma, and, and then most definitely CPR should and must be undertaken. So it's that level of nuance that will be difficult in the training, and I, and I have no, no doubts that that will be - can be to a, to a degree be difficult.

I guess in the case of penetrating trauma - and to a degree in blunt trauma as well, but let's stick with penetrating trauma - there are, there are a number of things that should be addressed in priority, and then maybe a consideration be given to CPR after that. And interestingly enough, those things are addressed actually in the Ten Second Triage. So we want to open an airway, make sure an airway is clear. We want to stop obvious haemorrhage if we can, and in order to do that we need to identify where haemorrhage is coming from, and we talk about those at-risk areas that are often missed, particularly in the junctional areas. And then if we've addressed the airway and we've addressed

points of obvious haemorrhage, then it's maybe at that point we might want to consider chest compressions from a police service point of view. That will be different for an ambulance or health service.

SULLIVAN: And that was another observation from the panel, that there is a need for officers to assess potential sources of bleeding even by moving the patient?

WITNESS MAZUR: Yes, so, so one of the - and again, I, I saw some really excellent demonstrations of that, and that particularly relates to the police care of Mr Tahir, who - we talk about creating space. So if you're trying to work or take care for an individual in a cramped environment, you can't do it successfully. So one of, one of the key principles that we operate to is "create space". So move the patient to an area whereby you get at, at best 360 degree access to the patient if you can, and that may mean - that will mean moving them.

The other thing is that you need to expose them, and that will be, I, I suspect something new or newish to police, if they were to undertake this and that. So you can see the areas where people are most significantly at risk of a catastrophic haemorrhage or, or dangerous haemorrhage and they are armpits, groins, back, buttocks, which are areas that are hidden. So you need to roll a patient, and you need to expose those areas to see are there other injuries apart from the obvious that I'm missing that I need to put direct compression on.

SULLIVAN: Before I move to my last topic, any reflections from Dr Evens?

WITNESS EVENS: Thank you. I agree with Dr Mazur about the commentary about the exemplary actions of the police officers within their current scope of practice and work. With regard to CPR and whether CPR causes harm, I'd highlight again that within the doctrine for the treatment of traumatic cardiac arrest, CPR is de-emphasised but not removed.

SULLIVAN: Yes.

WITNESS EVENS: And that is because it is because it is not possible to be certain of the diagnosis, only what is probable in the diagnosis, and therefore I think although CPR in the context of hypovolemia may cause theoretical damage to the heart, at the point that you have begun CPR in that circumstance there is no probability of survival, so you have not materially caused any harm. But--

SULLIVAN: And related to that, it's difficult for a police officer to make a clinical judgment about where they fall in that spectrum as well--

WITNESS EVENS: It should, it should not be expected.

SULLIVAN: Yes.

WITNESS EVENS: There is a question though about CPR in a major incident, and that really relates to the availability of resources and whether continuing CPR prevents that person from moving on and undertaking other potentially lifesaving activities, and that could be a police officer or anybody else, and that is as Dr Mazur says addressed in the Ten Second--

SULLIVAN: Ten Second Triage tool.

WITNESS EVENS: --Triage tool. Penetrating trauma is rare in New South Wales, although I think many of my colleagues would suggest that there is an increasing rate, albeit much lower than we experienced in the UK. And I do think again really within the discussion about Ten Second Triage, but also out - with that, if I reference my experience working with the Metropolitan Police in London and the training they receive with regard to the management of penetrating trauma, in, in some ways often related to the work of Colonel Parker who we've referenced previously, there are opportunities to provide further training and experience for police officers with regard to this condition given that there may well be an increase in prevalence in New South Wales.

HER HONOUR: Thank you. Dr Cowburn.

WITNESS COWBURN: Again, I very much concur with the views of my colleagues, and, and I think I, I have a role in both national and regional teaching and clinical governance of police first aid skills, and I think these need to be balanced against the time spent in training, the equipment, and the prevalence of these incidents. However, if a Ten Second Triage or a similar model is adopted which addresses those life threatening severe haemorrhage and a willingness to expose to look for wounds in those junctional areas and other areas where bleeding internally may be going on, that will pay significant dividends.

Within the UK we have the College of Policing which defines a curriculum for all police officers, some of which are specialist firearms officers, will have much more advanced levels of training and competency and equipment to go with that. But that has to be tailored to the perceived and actual need of those officers and what they are exposed to as part of their duty. Thank you.

SULLIVAN: I'd like to ask your final reflections now in my last question, acknowledging, if I may, the extremely difficult job that our emergency service responders undertake, and the very traumatic scene that confronted them on 13 April. I'll start with you Dr Mazur.

WITNESS MAZUR: Thank you. Yes, I, I think it's already important - we've already noticed but I, I just wanted to add to that, I think it's important to note that we're all here reviewing this event in this comfortable environment. So, so I think it's often easy with the benefit of hindsight and the comfort to, to make broad assumptions. So on that basis I, I really just wanted to acknowledge the skill, dedication and commitment to public, patient and colleague welfare I read about in the statements and that I witnessed on the, the video footage that I

saw, and impressed with the role and the, the job that both police and ambulance services and members of the public that I saw as well, which was very impressive, that occurred in the most trying of circumstances in this particular event.

SULLIVAN: Thank you. Dr Evens.

WITNESS EVENS: Thank you. I, I agree with Dr Mazur. I particularly want to acknowledge the impact of the police in terms of both controlling the threat and the bravery that that required, but also keeping our clinicians safe. And that that is very much appreciated. As I reviewed these cases, I felt fortunate that the people who were in those circumstances through a combination of experience and instinct acted in the way that they did, and the motivation I took from reading this was a desire to make sure that as we serve the community of New South Wales in the future, there is less fortune and more assurance. But I say that having been part of a similar journey in a, in another country, and that, that this is not simple.

SULLIVAN: Thank you. And Dr Cowburn.

WITNESS COWBURN: Thank you, yes. The - my, my thoughts go out to, to all those involved, the, the, the friends, the family, the victims, but also the psychological impact on the responders and all those involved in this, this tragic incident. That is - the display of bravery, patient-centred approach from all the emergency responders that I saw on the footage, and from the statements, and the speed with which critically ill patients were transferred from the scene to definitive care was fantastic, and is an immense credit to, to both emergency services that were involved and their, their actions. And I think, I just wish to reinforce that everything I have put in my statements are finessing and critiquing what was an excellent response that did the very best to save as many lives as possible. And it's just learning from that to make it better in the future, and thank you to all those that, that acted that day.

SULLIVAN: Thank you Dr Cowburn. Your Honour those are my questions. If I can just acknowledge that this panel have worked under tremendous pressure from counsel assisting to prepare their reports at short notice and to make themselves available and we very much appreciate that.

HER HONOUR: Yes, we're very much indebted to you. Before I say any further comments, I'll just see if, and before we break, if there are any other questions?

HARRIS-ROXAS: Your Honour, no questions from me.

FERNANDEZ: No, thank you, your Honour.

SPEAKER: Not from me.

SPEAKER: Nor from us, thank you.

CALLAN: Your Honour, I have about six questions, two short topics.

CHIU: If I could go last, but at the moment I have no questions, your Honour.

HER HONOUR: I'm just wondering if you need a break. I'm very conscious of Dr Cowburn, the time over there is very early in the morning.

WITNESS COWBURN: I'd be happy to continue, yeah.

HER HONOUR: All happy to continue?

WITNESS EVENS: Yeah.

WITNESS MAZUR: Yeah.

HER HONOUR: All right then, we'll continue. Ms Callan?

CALLAN: Thank you. Dr Mazur, Dr Evens and Dr Cowburn, my name is Sophie Callan, I appear on behalf of the New South Wales Commissioner of Police and her officers. Can I ask you, on the topic of interagency communication, in, Dr Cowburn, your supplementary report, you reference various forms of interagency radio communication and usefully describe the way that that might operate. You collectively, in the table which has been tendered as exhibit 7 today, refer at point 6(b) to the desirability of a joint radio communication channel between agencies.

Can I ask this first of you, Dr Cowburn, is this correct: you're not saying that New South Wales should necessarily adopt these examples you give specifically that are used in the UK, but they're provided as a means of usefully considering the types of communication methods which might improve interagency communication?

WITNESS COWBURN: Yes, so I, I am framing this very much in the context of my UK practice, so this is what I am used to. I think it is more the concept rather than the exact mimic of it that I would be interested in. The ability for emergency services to communicate between each other is extremely useful. When I am working in my pre-hospital practice, if we have an instant that may be considered your equivalent of an active armed offender and I am in a team, I am aware that there is a police channel that I can go onto to gain information and also give information as to where our location is, which will speed the transport of either ourselves into the scene, ensuring that it is safe enough for us to approach, or getting the patient out to us. So that, that interagency communication does bring significant benefits. How that is achieved within the systems you have is up to New South Wales to, to deliver.

CALLAN: In that vein, to your observation and experience, is that informed by things like, first of all, technical considerations and limitations, for instance, you say in the UK all agencies utilise the same radio system referred to as Airwave?

WITNESS COWBURN: That is one that we are currently using. There is a project ongoing to update that because that system has been in existence for quite some time now. And obviously this would be within the constraints of whatever systems you are utilising, but there are significant benefits in all sharing a common modality of communication. Even though, particularly in the expanse of New South Wales, you may need different technical resources for different environments, having one that is shared is extremely useful.

CALLAN: Is it also correct another consideration must be security, that is that the system being used by involved agencies is encrypted or otherwise kept secure?

WITNESS COWBURN: Yes, indeed. So all of our Airwave radios are tracked and logged, and for those that - those of us that operate in a more, more high side security role, we have specific radios and channels which are not accessible to others.

CALLAN: Can I suggest a third consideration which emerges from the evidence is managing congestion, that is the number of radio transmissions on a particular channel, is that correct?

WITNESS COWBURN: Yes, this comes down to good quality radio procedure between those using them, and also agencies having multiple channels on which they can communicate for different tiers of staff. So if I use an example within my, my regional ambulance service, we will have five major incident channels which means we can run simultaneous incidents, should they be geographically spread, or we can run different tiers of command on different channels, enabling people to swap between as required, so that no one channel becomes overloaded with communications.

CALLAN: Thank you, that's most useful. Off the back of that answer, it seems that a perhaps fourth point that emerges that I've identified in the evidence is it's important to keep an eye on the cognitive load of, for instance, multiple communication methods in a major incident, particularly for Commanders, is that right?

WITNESS COWBURN: That, that's very valid and, you know, a lot of this, this cognitive load can - or being able to offset the cognitive load comes with training, exercising and competency and exposure, but yet you always have to be - you know, you have to be aware of the cognitive burden on your Commanders which can be extreme.

CALLAN: Dr Mazur, can I ask, do you have anything to add on this topic?

WITNESS MAZUR: No, particularly around radio technology, definitely not. What I will say is that, just to emphasise your point that - and we've mentioned it a couple of times - is the overload is a risk. We, we did discuss, but this would be something for individual services to consider as part of their plans, whether it would be beneficial for a dedicated comms person to be aligned with a Commander who could filter the information coming through, pass it to the

Commander and then get information to put back a radio, radio operator, I guess, for want of a better term, who is specifically linked to the Commander that was receiving or giving all that information, it is almost a first filter.

CALLAN: Yes, and I think you make some reference to that in your table.

WITNESS MAZUR: Yes.

CALLAN: Dr Evens, do you have anything to add?

WITNESS EVENS: No, I, I agree with Dr Cowburn's answers. Broadly, and I would say that my experience of Westminster Bridge was that the radio operator was a really critical role, really relating again to cognitive load, and the ability of any Commander to both monitor communications whilst also providing command functions, but I think that's a very specific operational concern. The broader principles about what must be achieved are more important than the specifics of how a radio solution works.

CALLAN: Can I move to a separate topic and that is the concept of a joint rescue taskforce which you address in the table which is exhibit 7 at point 11. You were directed to some evidence that's before this inquest, including of Senior Sergeant William Watt, and asked to comment on the potential utility, based on your experience, of a joint rescue taskforce. Your response, Dr Evens, with which Dr Cowburn and Dr Mazur expressed agreement, was "didn't collectively support the view that a rescue taskforce was a necessary response to this incident". You go on to say:

> "The term referring to a static concept with a specifically trained group of individuals, which does not allow the flexibility required to access the scene and previously described dynamic approach to risk, should allow rapid access of clinicians to patient appropriate to risk."

I think it might be important to be clear as to what, if I start with you, Dr Evens, you understand by the concept of a rescue taskforce, that is, were you conceiving of it as paramedics with special training equivalent to the SOT?

WITNESS EVENS: I was conceiving it with reference to I think particularly the discussion in the Manchester Arena Inquiry which examined the utility of the RAID concept in the French emergency response service, meaning a tactically trained group of clinicians, placed with a police tactical response, going into situations of extreme risk, and the discussion there was really with reference to the Bataclan siege situation. That is a very specific set of circumstances and there exists within New South Wales tactical paramedics who are, who work with the police, who are, as I'm sure you're aware, who are deployed in circumstances where the police deem that that is necessary at present.

The point I think I really wish to make was that delaying access to patients to assemble a very specific tactical response clinical group embedded with a police group is likely to delay access to care for the majority of patients, and

the focus I feel should be more on either, firstly, improving access of all responders to patients commensurate with risk; secondly, rapidly extricating patients from the area of risk to other areas, as opposed to delaying and then preparing to go in outside I think of the specific environment of siege; and thirdly, through equipping people who are able to access that scene, namely the police, with the skills, as described in the discussion about Ten Second Triage, to effect immediate first aid.

There is an inverse relationship I guess between the complexity of clinical care that can be provided and the ability to responsively provide that care. And so there was discussion in the, in the discussion about the RAID-type response, the French embedded response in, in other inquests with regard to things like providing surgical airway, and I would say that the inflexibility that would result from taking a very small group of clinicians who are able to provide that, namely in New South Wales physicians, and training and then embedding them and gathering such a team that could then go and do that, is not preferable relative to a flexible approach that rapidly extricates those patients to a place where it can be done.

CALLAN: To follow from that very useful contribution, Dr Evens - and I think this might be a point that was made earlier - that in effect what Inspector Brett Simpson did on the day, to the extent that there was attendance by ambulance personnel accompanied by police, reflects the kind of flexibility that you would regard as desirable to manage the competing considerations of risk and attending to patient care without the static strictures of a sort of more formal taskforce model.

WITNESS EVENS: I agree. I think that is exactly what happened. In all of my practice on the streets in New South Wales, today the presence of New South Wales Police officers changes the risk to me and therefore changes the risk - changes my ability to access patients, just in, in many circumstances. What is important, and the co-training and co-understanding and sympathy with each other's capabilities, is the ability of people to go: what is the risk in front of us right now? Does, for example, the presence of a single police officer sufficiently reduce the risk? Or is the opinion of the police officer is that they need more resources than that? What do we need to do to mitigate the risk such that clinicians can access patients, or if not, the patients are rapidly extricated? It can't really be prescribed but the principles can be understood.

CALLAN: It sounds - and you used the word "co-training" - that as the relevantly involved agencies might develop together their thinking around such an approach, that then appropriate training is essential so that it can be implemented in a way that achieves the objectives.

WITNESS EVENS: Yes, appropriate training and training of appropriate fidelity, such that the different emergency services workers truly understand the capabilities and the needs of the other services. And I think - I, I go back to the summary review paper that was presented earlier about the learning or the inability to learn from previous incidents, and, and what I take from that is that there are assumptions made which don't hold to be true, and we can assume

that emergency services workers understand each other's capabilities and risk postures and ability to mitigate risk, but that assumption is often then not held to be true unless we have taken active steps to enable each other to, to understand each other.

CALLAN: Dr Mazur, do you have anything to add on this topic?

WITNESS MAZUR: No, I think Tom's eloquently explained that.

CALLAN: Dr Cowburn?

WITNESS COWBURN: I would completely concur with Dr Evens. And within the UK - I have to, I have to be cautious how I frame my answer, that I don't stray into areas that, that are official-sensitive, but outside of a siege situation or a pre-planned operation, I do not see any significant benefit in the embedded model. What Dr Evens has described and what was actually described by Inspector Simpson on the day is the most effective way to save lives.

CALLAN: Thank you. Those are my questions. Thank you.

HER HONOUR: Thank you, Ms Callan. I'll just check if there's anyone in court 2 before I go to you, Mr Chiu.

SPEAKER: No questions, thank you, your Honour.

JORDAN: No questions, your Honour.

SPEAKER: No, thank you, your Honour.

SPEAKER: No questions, your Honour.

SPEAKER: No questions, thank you.

HER HONOUR: Thank you.

CHIU: I have no questions, your Honour.

SULLIVAN: And there's nothing arising, your Honour.

HER HONOUR: Not surprising. That just leaves it for me to say that we now have the benefit of your immense expertise and I'm most grateful, it's world-class the evidence that you've given, you've spent so much time in preparing the reports, time you spent in conference with counsel, and it's incredibly important to the death prevention function of this jurisdiction, and I'm most grateful, so thank you, you're now excused, thank you very much.

WITNESS EVENS: Thank you. Thank you, your Honour.

HER HONOUR: Particularly thank you to you, Dr Cowburn, for the terrible

hour that it must be where you are now, I hope you can get some sleep.

WITNESS COWBURN: I may go and rest now if that's okay, ma'am.

HER HONOUR: You may go and rest, yes. Thank you very much.

WITNESS COWBURN: Thank you.

<THE WITNESS WITHDREW

AUDIO VISUAL LINK TO ENGLAND CONCLUDED AT 1.32PM

HER HONOUR: Now I note the time.

SULLIVAN: 2.15, would your Honour--

HER HONOUR: 2.15 we'll come back.

SULLIVAN: Yes, thank you.

HER HONOUR: Thank you.

LUNCHEON ADJOURNMENT

HER HONOUR: Dr Dwyer.

DWYER: Your Honour in the witness box currently we have our expert panel related to the care of Mr Cauchi by general practitioners. And I call our panel, Dr Edwin Kruys, and Dr Hester Wilson. I would ask that they be sworn in.

HER HONOUR: Yes, thank you.

LTS:DAT

<HESTER WILSON AND EDWIN KRUYS, AFFIRMED(2.24PM)

DWYER: Dr Wilson, if I might start with you, I know you're no stranger to this Coroner's Court. Could you please tell the Court your full name?

WITNESS WILSON: It's Dr Hester Hannah Katherine Wilson.

DWYER: And your current practice address?

WITNESS WILSON: There's a number.

DWYER: Well I withdraw that question then. What are your current roles within general practice?

WITNESS WILSON: So at the moment I'm not working clinically in general practice. I am undertaking a PhD, looking at general practitioners' experience of a particular area, and I'm working in a, in a role in the State system, and part of that role is looking at how do we work better with general practitioners. It - it's population and community health, so outpatient based.

DWYER: You're a clinician with over 30 years of clinical experience, and you've had a number of specialties within general practice, is that right?

WITNESS WILSON: That's correct.

DWYER: You explain in your statement that your areas have covered sexual health, women's health, mental health and addiction medicine, correct?

WITNESS WILSON: That's correct.

DWYER: And you've given evidence as I alluded to in this Court on a number of occasions, particularly with respect to inquests concerning addiction deaths, or--

WITNESS WILSON: That's correct.

DWYER: And within the area of mental health, are any of the areas that you're working on now related to mental health specifically?

WITNESS WILSON: Certainly. A lot of the people that we see have both mental health and drug and alcohol issues, and in the population and community sector we - we're working with a group of people that have multi-morbidity(as said), so they'll have chronic health issues, physical health issues, mental health issues and drug and alcohol issues.

DWYER: Dr Wilson, you prepared a report that is dated initially January in 2025 and been revised in February 2025. Do you have a copy of your report in front of you there?

WITNESS WILSON: I do.

DWYER: Dr Kruys, you have also provided a report to the Court to assist in understanding the circumstances of Joel's treatment and how that treatment changed over a period of time. You're a general practitioner currently based on the Sunshine Coast in Queensland, is that right? You are nodding, we are going to have - have to use your voice--

WITNESS KRUYS: Correct, correct, yeah that's right.

DWYER: We're about to hear your accent Dr Kruys. Where did you initially train as a general practitioner?

WITNESS KRUYS: I trained in Amsterdam, the Netherlands.

DWYER: When did you come to Australia?

WITNESS KRUYS: That was in 2004, yep.

DWYER: Have you worked in Queensland since that period of time?

WITNESS KRUYS: No, I started in Western Australia, where I owned my own GP practice, and then I moved to Queensland.

DWYER: How long have you been in Queensland for?

WITNESS KRUYS: Since 2013.

DWYER: You explain in your outline in your report that you have a special interest in mental health. How did that come about?

WITNESS KRUYS: So in Queensland we have the GPSI model of care, which, which is GPs with a special interest, working in a hospital outpatient setting. And I'm working in one of those roles, as a GP within a hospital outpatients mental health setting.

DWYER: Is that called a GP liaison officer, or is it--

WITNESS KRUYS: No that's different. That's one of my other roles. So I'm also a GP liaison officer which is a non-clinical role, which is solely focused on improving the interface between the hospital specialist teams and general practice.

DWYER: So you're a GP liaison officer with the Sunshine Coast Hospital and Health Service, is that right?

WITNESS KRUYS: Correct, yes.

DWYER: In what way does that role improve the liaison between the hospital and private practice?

WITNESS KRUYS: So there's a lot of focus on improving communication, transfer of care, clinical handover, models of care whereby specialist teams can work together with, with general practice and primary care, and how you actually do that. And part of that role is also research into outpatient discharge criteria and communication to general practice.

DWYER: Both you and Dr Wilson have had a role at high levels in terms of governance in your fields of expertise. You are currently the co-chair of the Queensland General Practice Liaison Network, is that right?

WITNESS KRUYS: Yes that's correct.

DWYER: And you're the past president of the - sorry, past vice-president of the Royal Australian College of General Practitioners?

WITNESS KRUYS: Correct.

DWYER: And a current council member for the Royal Australian College of General Practitioners in Queensland, is that correct?

WITNESS KRUYS: That's correct.

DWYER: I'll return to those roles when we look at recommendations that might flow from lessons to be learned here. I'm going to work chronologically through the care that Mr Cauchi had. In the course of preparing for your reports, you of course have had the GP records that are most relevant, the records from Dr Grundy, Dr Ruge and Dr Pietsch, and you've also looked at the Mi-Mind records to try and understand the level of psychiatric and nursing care that was provided by the Mi-Mind Centre when Joel was discharged. You also looked at records in relation to the public health sector, is that right?

WITNESS WILSON: Mm.

WITNESS KRUYS: Yes, correct.

DWYER: So, starting with, if I may, the period from 2001 through to 2012 where, as you know, Joel Cauchi was managed within the public sector following a recognition of his first episode of psychosis, as it became known. Mr Cauchi was first made an inpatient at the Toowoomba Base Hospital after a period, after experiencing psychotic episodes which were characterised by threats of violence, some aggression, and hearing voices, including satanic voices. He experienced visual, auditory and tactile hallucinations.

Dr Richard Grundy was Joel's primary general practitioner from 2002 through to early 2020, so covering both the public and private sector. As you know, Joel was managed in the public sector up until 2012. So, I want to ask you some questions about what the role of a general practitioner is during that period.

Again, just a few facts by way of reminder of information that was available to

Dr Grundy during that time, not particularly for your benefit, but for those following the evidence. 2001, Joel was admitted. He was admitted a second time to manage some medication issues. The hospital and Dr Grundy were aware that Mr Cauchi's father, Andrew, was also a person who was living with schizophrenia and was not medicated and sometimes saw visions. First line antipsychotic medications were trialled for Joel between 2001 and 2002, but in October 2002 the medication regime was changed to include clozapine.

From 2001 through to 2012 there is evidence of the negative, positive and cognitive symptoms of schizophrenia, although his positive symptoms did stabilise. But in 2003, Joel was suffering positive symptoms, including auditory hallucinations, frequent spirit voices, including some derogatory comments made by those spirit voices. In 2008 he had occasional auditory hallucinations, which he described as thoughts, and ongoing difficulties with obsessive, compulsive symptoms. And in 2012 at the time of discharge, there was noted to be possible positive symptoms. What role did Dr Grundy play in managing Joel while he was within the public sector? Dr Wilson, if I could start with you?

WITNESS WILSON: I think that in terms of Dr Grundy's role, he was managing Mr Cauchi's general health. He had - he really didn't have a major role in the management of his serious mental health issues - the schizophrenia, or the management of clozapine, which is an uncommon medication and one that certainly me as a GP would not feel competent managing on my own.

DWYER: Sorry, I'm about to come to both of your experience with clozapine, but in those circumstances while he's in the general practice, Joel had access to a multidisciplinary team, including psychiatrists, psychologists, occupational therapist, clozapine monitoring, for example. You're nodding Dr Wilson?

WITNESS WILSON: Yes.

DWYER: I take it that's not controversial, Dr Kruys?

WITNESS KRUYS: No.

DWYER: In those circumstances, the role of the GP like Dr Grundy is really to monitor for things like rashes and the general things that we go to see a general practitioner for; coughs, colds, all range of general health issues, do you both agree?

WITNESS WILSON: Yes, that's correct. You might also in consultation with the specialist team take on some of the medical monitoring of, of chronic disease that is totally within our expertise. But certainly, it would always be collaboratively with the specialist mental health team.

DWYER: Dr Kruys, given that he was a patient in Queensland for this whole time, is that the same description in Queensland?

WITNESS KRUYS: Yes, I would, I would argue that that's correct. The majority of the mental health care and the clozapine monitoring happens in the mental health specialist sector, because it's not something that GPs have knowledge and know-how and skills about. But there's still a very big role for a general practitioner, and not just in a reactive way, with regards to the rashes - that's important as well - and the common colds and the coughs, but also with regards to cardiovascular risk management, screening for cancer, sexual health, lifestyle changes, immunisations, smoking, support with alcohol and other drugs.

Guiding patients through the healthcare system and coordinating care. Proactively managing their chronic disease, getting people back for health assessments. And checking in, how are you going, how are you feeling. And if there's any concerns you can flag that with the mental health team. Is there a dietician required. Is there a physiotherapist. Does this patient need psychological care. And again, liaising with the mental health team.

So, there is also a place for the GP to take a more proactive role. The problem is that it is often, GPs often don't know what an intensive clozapine program does and does not do. What are the roles and responsibilities, and vice versa. The specialist teams often don't know what the GP can and can't do. And there's room for improvement.

DWYER: In giving that explanation, Dr Kruys, are you referring to the role of the GP in both the public sector and the less usual circumstance where clozapine is managed privately?

WITNESS KRUYS: I think it doesn't matter where the patient's specialist team is based, whether it is private or public. The role of the GP is always the same, I think, yes.

DWYER: Dr Wilson referred to the issue of clozapine - I think I'll come back to you, Dr Wilson. You said that you wouldn't feel comfortable managing a clozapine patient on your own, is that right?

WITNESS WILSON: Yes, that's correct.

DWYER: Why is that?

WITNESS WILSON: It's, it's a risky medication. It needs a lot of monitoring, and it's not one that's commonly used. So, I am more comfortable and more knowledgeable with the more commonly used antipsychotics. You know, so in my career, having worked in general practice for 25, 30 years, I've had two patients that I've seen over that time.

DWYER: Who are on clozapine?

WITNESS WILSON: Who are on clozapine, yes, yes.

DWYER: Just jumping back a step, it's expected that general practitioners will

manage a whole range of mental health issues, sometimes on their own, correct?

WITNESS WILSON: Absolutely.

DWYER: That might range from acute episodes to chronic conditions?

WITNESS WILSON: We would be more likely to manage the high prevalence conditions, things like anxiety and depression. Whereas for your major psychotic disorders, things like schizophrenia or bipolar affective disorder, I would be looking for support from my specialist colleagues.

DWYER: Yes.

WITNESS WILSON: Low prevalence, high complexity. And so that need to have a specialist involved. I think the other thing, just thinking about our role with those low prevalence conditions, we know that there is high risk of, as you talked about, cardiovascular, the other chronic health issues. We wouldn't expect our psychiatry colleagues to be able to manage that, because it's not what they do. It is what we do as general practitioners.

DWYER: We heard yesterday from our panel of psychiatrists that the condition of schizophrenia can range in severity significantly, but treatment-resistant schizophrenia where patients end up on clozapine is a serious form of the illness. So that underscores what you're saying about GPs not managing that condition alone?

WITNESS WILSON: Yes.

DWYER: You've managed two patients on clozapine in a long career?

WITNESS WILSON: Yes.

DWYER: Who else assisted you in terms of the management of those patients?

WITNESS WILSON: Both of those patients were also continued to be engaged through the public mental health service. Had regular appointments with their psychiatrist or the psychiatric service there, and a case manager as well. And so, my role was looking after the general health care, following up and managing their chronic disease, getting them to see a dietician, an exercise physiologist. But it was very much a collaborative role. Though I have to say, there were times when I had to ring them and say, "So, you know, what's happening, you know, how are things going?" And there's certainly room for improvement around how we work together through those quite siloed and quite different working environments.

DWYER: I might come back to that issue generally very shortly with respect to some of the documents you attach. Dr Kruys, in your experience in Queensland and Western Australia, how many patients on clozapine have you

managed?

WITNESS KRUYS: As a community GP, in 20 years I've had one patient with clozapine, and I treated that patient under the shared care arrangement that exists in Queensland, whereby the psychiatrist takes the lead and prescribes, and the GP does do the physical monthly checks and the ECGs that need to be done.

DWYER: I see. So, were you responsible for monitoring the bloods there as well in that patient?

WITNESS KRUYS: No, I wasn't, interestingly. They checked the bloods before they prescribed, and that's because on the script, you actually have to write what the blood results are. And I was asked to do like the blood pressure checks and the heart rate, the weight, the regular ECGs.

DWYER: Is that a patient you're still monitoring?

WITNESS KRUYS: No, that's several years ago.

DWYER: Okay.

WITNESS KRUYS: Yes.

DWYER: During that period of time, you saw that patient how regularly?

WITNESS KRUYS: Monthly, yes.

DWYER: Did you have correspondence with the psychiatry team?

WITNESS KRUYS: Minimal, minimal, yes. Yes, yes, very minimal. We're not very good at communicating with each other, unfortunately. And that is, that is - there is definitely room for improvement as well, yes.

DWYER: Was that a private psychiatrist or a public sector?

WITNESS KRUYS: It was public, yes.

DWYER: Over what period of time did you manage that patient?

WITNESS KRUYS: So that was probably about 18 months, two years. And I moved onto a different practice then, so that I stopped looking after that patient.

DWYER: I see. So, the patient remained within that practice, is that right?

WITNESS KRUYS: Yes, correct, yes.

DWYER: I'll come to you both about discharge and the importance of improving practices in Queensland and New South Wales around that. But,

Dr Wilson, you have attached a number of documents that are guidelines for GPs. I just want to come to a couple of them. One appears at annexure A of your report. It doesn't need to come on the screen, but it's entitled "Clozapine in primary care". It's published by Australian Prescriber. What is that publication?

WITNESS WILSON: I'm going to have to find it, sorry.

DWYER: I'm sorry, so it's annexure A.

WITNESS WILSON: Well, the documents I've got are just - like it's a PDF with just numbers, so.

DWYER: I'll just bring that up for you then.

WITNESS WILSON: Yes.

DWYER: Page 106, annexure A.

WITNESS WILSON: So Australian Prescriber is a journal that comes out to Australian prescribers. It's a highly regarded journal with a very clear review process to ensure that the quality of what is put in that is, is high quality. And this one is - it's from about seven years, ago, and it's - eight years ago - and it's looking at the, it's really trying to summarise for us in primary care clozapine and its role.

DWYER: So, by way of example, if we could just look at page 107 of that same document. In that table is sets out management of the adverse effects of clozapine, and it's very much focused on the physical, which perhaps is not unexpected because it's a general practitioner. But it's things like neutropenia and cardiomyopathy, sedation, weight gain, nocturnal enuresis, or bedwetting.

WITNESS WILSON: Yes.

DWYER: And so we know that clozapine is a drug with a number of physical side effects, and they're set out there. If you look at page 111 of that document, under the subheading, "shared care" it notes, it suggests, "GPs are well placed to provide ongoing care for people taking clozapine". I'll pause there. In spite of both of you having had that very rare experience.

> "Essential components of GP shared care programs include agreed monitoring protocols and agreed prescribing responsibilities for prophylaxis and treatment of any clozapine related adverse effects. Close communication between clozapine coordinators, GPs and patients is essential for monitoring and management of patient's adverse effects and for ensuring that the patients are attending their GPs".

So that's fairly high-level stuff.

WITNESS WILSON: Yes.

DWYER: But there's nothing in this document about the risks for a patient and the community when a patient is taken off clozapine?

WITNESS WILSON: No.

DWYER: And the evidence of both you as experts is that actually there are challenges for the GPs in managing people who are taking clozapine, is that right?

WITNESS WILSON: Yes. Certainly, with one the people that I saw, they were, actually had a clozapine clinic in the public sector that they went to. And so the interactions that I had was with the very experienced clinical nurse consultant who was involved in managing that clinic. I had much more conversations with them than I did with the psychiatrist. It was a teaching hospital and so there was rotation, understandably, of psychiatry registrars.

But with the clozapine clinic, it was actually quite well structured, but there were issues with communication. And one of the things that has come out of that, and it is a research project that is running at the moment called the SHAReD Project, through UNSW, is looking at using technological tools to help in terms of that communication sharing. So that's still underway. I understand that the study has now finished and they're doing the analysis. But that was certainly, it did come out of the clozapine clinic where there was this sense of, we really do need to have an easy way to communicate.

Because one of the issues with communication is, you know, I ring and they're, you know, busy seeing patients or, you know, not at work. Or vice versa, they try and ring and I'm in with a patient. So those - you know, so you can put things in writing and, and, and that's good and with - in terms of the connections, it, it has improved with, with secure messaging, but also that ability to, to have conversations and, but also sort out protocols so it's really clear, what you do here is this and this and this, and, and if this happens, then, you know, you need to send the person back or give us a call. And we've got a really good example of that in antenatal shared care, whereas a shared care GP working with the maternity, it's really set up very clearly, at this stage you do this, at this stage we do this, and, you know, to support the, the woman and, and the foetus through the pregnancy.

DWYER: In the examples that you can think of, of the few patients you managed, did they maintain a steady dose of clozapine, as opposed to being weaned off or directed down?

WITNESS WILSON: Yeah. I, I - neither of them - they both stayed on their, their medication, it wasn't weaned down.

WITNESS KRUYS: Can I, can I add to that?

DWYER: Please, Dr Kruys.

WITNESS KRUYS: So, so starting up clozapine is very risky, that's usually done in hospital under close supervision. Once a patient has been stable under specialist care for a while, then you can consider sharing the care with a GP. If it is a patient, a complex patient or not taking their, their medications regularly or not attending appointments, then these patients are probably not the best for shared care with a GP. So it's usually a selection of stable, and with "stable" I mean there's no concerns about their mental health, there's no concerns about their physical side effects from the clozapine, that are under the shared care with a GP. And there's always a clear protocol that tells the GP do this, this, this, this, watch for this, this and this.

DWYER: Does that suggest then that if you've got a patient where the plans are to cease clozapine or to change the dosage significantly, that is not a good candidate for referral to the private sector or with GP management?

WITNESS KRUYS: As, as a GP, I would feel uncomfortable doing that because of the risks associated with it, and I would probably say to the psychiatrist and probably the psychiatrist would say, "We'll look after this patient while we're tapering the dose." It's usually the stable, steady-dosed patients that are shared care, in my experience, in my limited experience, I must say.

WITNESS WILSON: Yes, yeah.

DWYER: What we know in relation to Joel's case is that at the time he was discharged from the public sector to Dr Grundy and the Mi-Mind clinic, he had been managed in the public sector for a decade, he was on a very high dose of clozapine at 600 milligrams, and the psychiatrist letter around that time said, "I would be hoping to bring it down to a dose of about 400 milligrams and see if he can be maintained on that," and Joel was known to be someone who was very compliant with his treatment regime as directed. So he goes to Dr Grundy in those circumstances. The Mi-Mind clinic, as you know, had mental health nurses that saw Joel on a monthly basis, and Dr Boros-Lavack who also saw him on a monthly basis, and very soon after Joel came to her, she commenced weaning him down on clozapine, and I'll come to that shortly.

Before I do, in relation to the guidelines that might assist her, Dr Kruys, you mentioned this at page 5, if I could just have your report up on the screen, tab 6 of the expert bundle and we go to page 5 there, it's paragraph 24, scroll down to (d), you say there:

> "There are to my knowledge no guidelines to advise clinicians in Queensland about the content and frequency of outpatient correspondence. This also means there's no consensus on the minimum information contained in a discharge letter to the general practitioner, such as management recommendations, recommended GP review frequency and discharge, recommendations regarding driving capacity and use of weapons, risk to self and others, risk of relapse, red flags, early warning signs, and escalation pathways."

That's just a critical gap in the care of these very significant - patients with significant illness, is that right, Dr Kruys?

WITNESS KRUYS: Yes, yeah, I, I absolutely agree there, yeah. As I also outline in my report, inpatient discharge summaries is slightly different area, that's usually better organised, although not formalised. But there are in Queensland sort of minimum criteria for an inpatient discharge summary of patients who have not, have not been admitted so they're under the outpatient care of a private or public specialist, there's no agreement on what do we actually tell each other about this patient, and it is highly dependent on the specialist, what kind of information is, is transferred to the GP.

And it's, it's interesting, it's actually an area of a research study I do now, not in mental health, I think cardiology, and we co-designing that at the moment. So we're talking to the specialists and we say, "What is important that needs to be handed over to the GP?" We're also talking to the GPs and say, "What do you need to know for - to safely continue the care?" And we're also talking to patients and we're saying, "What is important to you that needs to be handed over from the specialist team to the GP team?"

So there is a need to co-design the information that is transferred, and not only that, but there is also a need to decide on the frequency, how often do we do that? Do we do that once a year or at the first appointment, at discharge, and maybe when there are significant changes, or after each specialist appointment? And that is a grey area at, at the moment and that's a concerning thing. And I don't think it's just in Queensland, I hear from my GP colleagues that that, this is actually happening across Australia.

DWYER: It seems to you and Dr Wilson and to us that this is a ripe area for a recommendation to come from this terrible tragedy?

WITNESS WILSON: Mm-hmm.

WITNESS KRUYS: Agree.

DWYER: Can I have on the screen, I'm just springing this on you, tab 793 at page 327? I want to show you the discharge summary or remind you of the discharge summary, this is within the Mi-Mind notes, this came from the public sector in 2012, and then when we get to 2020, I'll show you the discharge summary that was from Dr Boros-Lavack to Dr Grundy. So if you could just scroll down there, the information that was provided to Mi-Mind and Dr Grundy, bearing in mind Dr Grundy had been involved for some time, was:

> "Joel has been treated with clozapine and risperidone in the past with poor responses to these treatments. He has been stable since commencing on clozapine. He's now been treated with clozapine for around ten years.
>
> 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 do not interfere 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. This was managed by an increase in the dose of clozapine and an addition of aripiprazole. Negative symptoms remain a feature of his illness.

Joel spends much time at home and finds socialising difficult. Despite this, he has recently completed a Bachelor of Arts. Joel's side effect profile includes:"

And then it's listed, hypersalivation, nocturnal enuresis, and tiredness, et cetera.

"With the completion of his bachelor degree, Joel sought a gradual reduction of his clozapine dose to combat tiredness. He had considered doing this earlier but decided to wait until he had completed his degree in case he had a relapse of symptoms. A small reduction in dose to 550 milligrams at night was made in December 2011 from his previous dose of 600 milligrams.

In the past, Joel has been provided CBT" - that is cognitive behavioural therapy - "to help manage obsessive compulsive symptoms that had worsened on clozapine. In recent years, Joel has not required additional support outside of his routine clozapine reviews. Joel's care is now being transferred to Andrea Boros-Lavack."

What we know over those years is there was a severe example of psychosis in 2001. I reminded you that there were auditory, visual and tactile hallucinations. They also included, however, aggression and that doesn't make its way into the discharge summary. The nature of those hallucinations is not described in any detail in the discharge summary. There's a reference to "some positive symptoms" in 2008. What we know from a close review of those public health notes, though, is that he continued to have positive symptoms in 2009 and in 2010 and 2011 and in 2012. Does that discharge summary, do you think, provide sufficient overview or outline to, I'll start with the GP? Dr Wilson - sorry, Dr Kruys?

WITNESS KRUYS: I'm, I'm happy to talk to it but--

WITNESS WILSON: No, please go.

WITNESS KRUYS: Yeah. So, so one of my roles as GP liaison officer is teaching junior doctors in the hospital how they need to write a discharge summary and, and this wouldn't pass the test. It is a very - it's a reasonable summary but there's much more to it and, and, and what is missing is the

management plan going forward. So, so a discharge summary is, is a terrible name because it's like we're discharging you and, and that's the end of the line. It would be better to call it a clinical handover document because that immediately tells you what you're doing here, you're telling the next practitioner who's looking after this patient how they can manage that patient. And in this case, that is the private psychiatrist but it is also the GP that will always continue to be looking after this patient.

So what is missing here is a management plan for the GP, how often does the patient need to - what, what is the GP's role in here, and also recommendations to the patient. In Queensland there's a section to patients as well because we hand a paper copy of the discharge summary to the patient so they also know what is going on and you're empowering the patient and you're telling them what they can do.

DWYER: If there are capacity issues, if they consent to it being provided to their family members, let's take Joel as an example, his mother in particular, but actually both his parents were engaged in his care, and Joel consented to them being engaged in his care for the majority of the time that he was cared for in the public sector and at Mi-Mind, so that discharge summary can be given to them as well if there's consent from the patient?

WITNESS KRUYS: Yes, yeah, yeah, yeah, to the, to the carer, absolutely.

WITNESS WILSON: Can, can I just make a point? This was back in 2012?

DWYER: Yes.

WITNESS WILSON: As a GP back in 2012, if I'd looked at that, I would go, "Oh, so this is being managed, this serious health condition is being managed by the specialist in the private system, been referred by the public system, so they're appropriate, so I'm just going to continue doing the other, but there, there isn't really a role in this for me, this is just for noting."

DWYER: So by "the other", you mean the general health stuff, the managing heart conditions, et cetera?

WITNESS WILSON: Yeah, yeah. Yeah, yeah. So he, I mean, he was a young man and he was, you know, seen for the coughs and colds and, and, and rashes and, yeah, but also the chronic disease, as, as was needed, but it certainly it's like, "Oh, this is for noting, I'll put it in my file, good to know, I'll record that diagnosis, you know, who's managing it, but it's not, actually doesn't really involve me."

DWYER: I take it you wholeheartedly support Dr Kruys' opinion that there needs to be clear guidelines which bullet point exactly the sort of things that are set out by Dr Kruys in the paragraph I just took the Court to?

WITNESS WILSON: Absolutely, yes.

DWYER: We will work with you after today to develop those guidelines for suggestion. Can I take you to some of the correspondence related to Joel then? Firstly, in chronological order, the letter, so this is at tab 788 where most of the notes from Dr Grundy's clinic are. There's a note from Joel's mother Michele at page 221, tab 788, it notes:

> "Dear Dr Grundy, Joel has been a client of the clozapine clinic at the hospital for a number of years now and at his last monthly visit he was given the option of seeing a private psychiatrist, Dr Andrea Boros-Lavack from the Mi-Mind Centre, however, in order to have an appointment, he has to have a reference from a GP."

So that's just a request from her for a referral letter. You see that letter at page 220. That doesn't say anything to Dr Boros-Lavack other than the medication that he appears to be on at that time, and a note about the conditions, but Dr Boros-Lavack did get the document I just told you about from the hospital. And then there's a letter from Dr Boros-Lavack which is at page 222 thanking Dr Grundy for referring Joel to her, setting out her preliminary diagnosis, some vulnerabilities that she noted, and her initial plan, "I have continued his clozapine 550 milligrams and Abilify 5 milligrams at night and will explore possible adjunct vitamin issues." She says:

> "I believe you'll need to do some CBT for OCD and to address his low social confidence and avoidance behaviours in the future. I will refer him to Dr Paul McQueen, psychologist, his case manager. And I will keep you informed about his progress. Thank you for involving me in his care."

So there's at that stage, nothing from Dr Boros-Lavack to suggest that anything is required of Dr Grundy by way of mental health review, is that fair?

WITNESS WILSON: I - on the basis of that letter--

DWYER: Yes.

WITNESS WILSON: --yes, yes.

DWYER: And should--

WITNESS WILSON: And we might, we might say actually there is a role, but on the basis of that letter, as a GP you could go "Fine, the, the specialists are managing it. I'm here. They can let me know if there's anything I need to do. I'm going to continue to be his GP and manage his general health issues."

DWYER: That might be on the basis of that letter but - and I think you both agree about this - Dr Kruys, what should be the role of a GP ongoing after that management within the private sector?

WITNESS KRUYS: So like I said, you know, check, check his blood pressure. Check whether he has skin cancers. Check his sexual health, any concerns

there. Lifestyle changes, diet, exercise, immunisations, smoking if that's applicable, and support with alcohol and drugs, if that's applicable. Guiding patients, because they're so anxious to attend healthcare professionals, guiding them and providing support and reassuring them and explaining to them why it is important that they look after themselves, and being that trusting person that they feel safe with, that they can open up to. That is an incredible, important counselling role of the GP as well.

DWYER: So would you - in this circumstance - I'll take you to some letters where it was apparent that Dr Boros-Lavack began a process of titrating down the dose of clozapine that Joel was on, and I'll take you to a letter in 2015 from a specialist. In those circumstances, where the doses were being titrated down, a couple of questions: first, would you expect a general practitioner in Dr Grundy's position to understand the risks associated - the mental health risks associated with titrating the dose of clozapine down, Dr Wilson?

WITNESS WILSON: Look it's - once again, it's a, it's an uncommon medication. From a kind of theoretical point of view, you would be thinking, "Okay this - so this young man has been controlled on this. He's got, you know, treatment-resistant schizophrenia. There is a risk, and I" - there was a letter at one point for a second opinion.

DWYER: Yes I'll come to that shortly.

WITNESS WILSON: Yeah, that did point to that. But in any detail, I, I, I, I don't, I don't think so, not as a GP, that you wouldn't be expected to have that specialist knowledge.

DWYER: So you would be expecting the psychiatrist to be managing the review of Joel, as he was being titrated down, and in fact there was regular review by Dr Boros-Lavack and by the mental health nurses.

WITNESS WILSON: Mm.

DWYER: So as a general practitioner would you be expected to be able to leave it to them in terms of understanding any early warning signs, or would you yourself as a general practitioner be expected to play a role in looking out for those signs? Dr Kruys?

WITNESS KRUYS: So, so with those letter - with that letter you just showed, I have the same feedback as with the discharge summary from the public sector. There is no management plan for the GP. And you can - and, and it is the role and responsibility to wean people off clozapine, because that's too complex for a GP. But that doesn't mean that you cannot share the care. Like you could say:

> "We are weaning the patient off, and we're looking out for these and these symptoms. Thank you for looking out for this risk, or this risk or that, and for regularly checking in on, on him. Please let me know if you find anything X, Y, Z."

Then you are suddenly sharing the care, and that is a much safer situation I think.

DWYER: And when you say you're looking out for this, this and this, you should - is it the case that there should be a spelling out of the signs and symptoms you are looking out for?

WITNESS KRUYS: Absolutely. Be as specific as, as you can. And, and, and I always say don't be ambivalent in your letters. Spell out exactly what you want the GP to look out for.

HER HONOUR: Can I just ask you at this point if - and that point of the interactions with the specialist and the GP, would a GP then be expected to get in touch with the patient to say, "I need to check on you"? To recall the patient?

WITNESS KRUYS: So, so in this case--

HER HONOUR: At that point?

WITNESS KRUYS: At that point. So this is a, this is a, a complex area, because the clozapine clinics are monthly already, so they are quite intense. But I assume that a patient sees their GP also regularly. So it, it, it entirely depends on what you decide here. Are you going to share the care like Dr Wilson just said, in antenatal shared care where the patient sees the midwife in hospital one month, and then the following month the GP, and it's exactly spelled out what you check, what you do and when. Or is it the specialist taking ownership of this, but just informing the team that may also see and come across the patient, maybe he comes to the GP for another reason, maybe he comes for his flu vaccination?

But if you know that this is happening as a GP, you say, "How are you going? How are you feeling? Have you got - I heard that they are tapering down your medications, have you got any of this, this and this and this?" If you inform the team, the treatment team of what you're doing, you're increasing the safety of the care of the patient.

HER HONOUR: I understand but I'll--

WITNESS KRUYS: But, but it's still the monthly controlled by the specialist.

HER HONOUR: Yes, I mean I'm really just talking about the logistics of getting in touch with someone who is not necessarily very organised. How would you do it as a GP? Do you ring them? Do you write a letter to their residence, which--

WITNESS WILSON: Well with - in general practice we have protocols for how we contact people, so that you've got, you know, their contact, you've got their, their phone number. You know you would have mum's phone number

potentially, you know because mum is a really important support, support person. So you would call, you would leave a message. You, you know - and it, and it, and it really would be what is needed for this particular issue? How hard--

HER HONOUR: It'd be--

WITNESS WILSON: --do I follow this up, and--

HER HONOUR: Proactive.

WITNESS WILSON: You'd be proactive, yeah. And, and if you couldn't get through to them then it'd be a letter.

HER HONOUR: Mm-hmm.

WITNESS WILSON: I've certainly had times in the past where I've gone and knocked on someone's door, cause I'm - there's a particular issue that I just really want to be sure that they, they follow up. You know, so I think, I think from, from my point of view, and, and I, you know, do acknowledge that we're looking back in time, and we're, we are becoming more aware of this. But it's, it's a, it's, it's, it's a missed opportunity--

HER HONOUR: Yes.

WITNESS WILSON: --to have more oversight and more support for Joel, and as general practitioners, we see people long term. And we develop very strong therapeutic alliances, and there's high levels of trust. And so to - so for Joel to have that opportunity, for us to know what we needed to ask--

HER HONOUR: Yes.

WITNESS WILSON: --"If you have these, come and see me, you know? If anything's happening, come and see me." It's a, it's another safety measure, and, and as I say, I think it was a missed opportunity.

HER HONOUR: Yes, and we'll get more to that towards the--

WITNESS WILLSON: Mm.

HER HONOUR: --the discharge letter. I mean it had been 18 years that - the relationship by then, but we'll get to that.

WITNESS KRUYS: And if I can add one more thing. I think there is a, a group of patients that may not be appropriate for GP shared care, because in the, in the early stages of their care, and they're usually in the public system, who also do outreach. But once they stabilise and come under the care of private psychiatrists, usually things are more stable, and they also attend GPs regularly.

HER HONOUR: Yes.

DWYER: And one of the bases in which Joel was managed in the private sector after 2012 was that he was deemed to be compliant and responsive--

WITNESS KRUYS: Yep.

DWYER: --at that time and for a long time afterwards. Between 2012 and 2015, if I could just summarise because I'll take you to 2015 shortly, the Mi-Mind psychiatrist, primarily Dr Boros-Lavack, but her colleague if she was away, provided regular correspondence to Dr Grundy outlining Joel's mental health status as his medication was changed. By way of examples if you need to see any of it, at tab 788, the main file, there is correspondence from 10 April 2012 at page 225.

So you will note that that says, "I reviewed Joel today. He would like to see how he goes on a decreased dose of clozapine. I've agreed to titrate his dose down effectively." Those sorts of letters are provided as you will have seen, on the - these don't need to come up, but 16 January 2013, 13 March 2013, 13 January 2014, 8 May 2014, 13 July 2014, 17 December 2014, 14 January 2015. I will just bring that last one up, that's at page 281, 14 January 2015.

So it's fair to say, isn't it, there's very regular letters, short letters, but letters back from Dr Boros-Lavack to Dr Grundy. Just looking at that last one:

> "I met Joel and his mum today. He's been progressing extremely well, and together we've decided to cut his clozapine back again, thank you, with a 25 milligram decrement, which was the usual."

So it indicates that mum's there. Mum's supportive. Altogether we've decided to cut his clozapine down. He's doing extremely well. Is that sufficient information for the general practitioner who is also responsible for the shared care, Dr Wilson?

WITNESS WILSON: If this was shared care, probably not. Once again, what this says to me is, "We've got it under control, just for - noting for your records". There's nothing in this that suggests that the, that the general practitioner is an active participant in his mental health care.

DWYER: In fairness, I just want to take you to this next one before I come back to you Dr Kruys, on 6 May 2015, Dr Boros-Lavack writes a letter to Dr Grundy, and this is in relation to the second opinion, it's the one second opinion that is obtained by another psychiatrist at that time, page 287. And she says:

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

I just want to pause for a moment. Dr Wilson as someone who's managed a couple of patients on clozapine, do you have an understanding of what that dose would mean of clozapine?

WITNESS WILSON: Not really.

DWYER: Dr Kruys?

WITNESS KRUYS: I don't think most GPs would know, the dose, no.

DWYER: So she goes on to say:

> "He was started on clozapine for his first episode of schizophrenia at age 17, not responding to olanzapine and then risperidone by Dr Nicky Stephens in 2002. With the advent of Nicky coming to private practice, I've approached her to give her a second opinion regarding Clopine. What would be his optimum dose? Could we switch him to another medication, eg, continuing the dose of Abilify?"

She says, "I do believe Joel needs an antipsychotic for long-term relapse prevention." I'll pause there. Dr Wilson, is it your experience with treatment-resistant schizophrenia, noting that you wouldn't manage a patient without other shared care, but that a patient suffering treatment-resistant schizophrenia at any stage of their life would need an antipsychotic long-term?

WITNESS WILSON: That would be usual. It would be unusual for it not to.

HER HONOUR: Dr Kruys?

WITNESS KRUYS: I'm, I'm not - I think so, yeah I think so. But I'm not sure that most GPs would have that knowledge, because treatment-resistant schizophrenia is something that specialists manage and not GPs. But we know that schizophrenia is a chronic relapsing condition, that needs ongoing, ongoing care.

DWYER: A report was received in response to - sorry, that letter again notes that "both Joel and his mother consented to me asking for a second opinion", which might be relevant as we come through the timeline. But a report was received back from Dr Stephens at page 289 it appears, and over onto page 290. You have both had the opportunity to read this previously, but just pointing out some highlights from that letter. Dr Stephens notes the history of Joel's first developing symptoms at 17, and that they didn't resolve with the first two antipsychotics, risperidone and olanzapine and he was established on clozapine. He appeared to do well on quite high doses of clozapine and his positive symptoms resolved completely. I'll pause there. That's not correct is it, to say that Joel's positive symptoms resolved completely, given what we know at the time of discharge--

WITNESS WILSON: Not, not on the basis of the information from his public mental health consultation notes, no.

DWYER: She says there that Joel told her that he has had no further relapse of positive psychotic symptoms in the intervening 14 years, and he has remained compliant in staying off drugs and alcohol. There's a note here that although he has been:

> "He has managed to complete a university degree part-time, he remains reliant on his very supportive mother to organise him, provide social interactions, and he continues to live at home. He has been able to tolerate clozapine quite well with no problems with neutropenia, no significant weight gain or metabolic syndrome, his echocardiograms have been normal. However he's suffered with some OCD symptoms and anxiety about cleanliness, none of which particularly affect him now.
>
> In consultation with his regular psychiatrist Dr Boros-Lavack, Joel has been slowly reducing the dose of clozapine from 600 milligrams down to 275 with no signs of relapse. I have discussed with Joel and his mother today the potential risks and benefits of stopping clozapine medication. The risk of relapse of positive symptoms and also potential exacerbation of negative symptoms and the attendant impairment in functioning and disruption to his ongoing study and lifestyle.
>
> The benefits of a trial off clozapine would be to reduce the ongoing risk of potential side effects such as neutropenia, cardiac side effects and metabolic syndrome, and to determine whether his illness is manageable on a less complex antipsychotic medication such as aripiprazole for the longer term."

It goes on to note that:

> "Joel will continue with the trial of a further slow reduction of clozapine at a pace of 25 milligrams less every three to six months with ongoing monitoring of his mental state by himself, his parents, and Dr Boros-Lavack. He agreed that if there was any recurrence of early warning signs of psychosis, then the reduction would have to be abandoned and a return to slightly higher doses of clozapine would most likely be the recommendation.
>
> Joel was aware of the importance of continued abstinence from illicit substances or alcohol and of managing his level of stress during this period of time. His mother was agreeable to support him during 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 warning signs of relapse".

So do you both agree that given the content of those letters, it appeared at that

time in 2015, that Dr Gundy was being told a number of things, but including that the reduction of clozapine did carry a risk of the return of positive symptoms, that the plan was that for Joel to continue on some form of antipsychotic in the future, that signs of - that there was an agreement, a therapeutic agreement between Joel and Dr Boros-Lavack that if there were signs of relapse, he would go back on some form of clozapine, probably, that Joel didn't have a good memory of the signs of positive schizophrenia, or psychosis, so the opinion of family members would be given significant weight? And that signs of relapse would be closely monitored by those at the Mi-Mind Centre, Dr Boros-Lavack and the nurses?

Do you have a comment on that in relation to any assistance for the GP involved in the management of Joel's mental health as well as physical health? Dr Wilson?

WITNESS WILSON: Once again, that's a letter that says to the GP, just for noting. The GP's not mentioned as part of that team. And so as a GP I would look at that and go, "It's all in hand, they're managing it, there's two psychiatrists that are saying this is appropriate". You know, but once again, I think it is a missed opportunity to have more support for Joel who had this chronic relapsing condition.

DWYER: Dr Kruys, do you agree with that, or want to add?

WITNESS KRUYS: Yes, I think there's a lot of valuable information to inform the GP, but I agree that it is not incorporating the GP in the ongoing management. It's advice to the original psychiatrist who wanted a second opinion whether they were on the right track.

DWYER: Could I have page 340? I'll just jump to December 2016. On the 14th of that month there was a note from Dr Boros-Lavack to Dr Grundy with a consultation record from the Clopine clinic. It advised that Joel was enjoying a university break with leisure activities and overall doing extremely well. He was working on becoming independent. His neutrophils were stable, schizophrenia is sustained, full remission on treatment. And the plan was to continue with Clopine discontinuation, cut down from 125 to 100 milligrams at night.

The indication there is that Joel is still doing extremely well. The note that schizophrenia is sustained, full remission on treatment, I'll just ask you to pause and reflect on that. The evidence from the psychiatric panel is that in fact Joel continued to experience throughout the course of his chronic disease, or chronic illness, I should say, negative symptoms and cognitive symptoms, would you expect a GP to just know that, or should that be spelt out?

WITNESS WILSON: I think it needs to be spelt out.

DWYER: Dr Kruys?

WITNESS KRUYS: I agree, yes, yes.

DWYER: We have had evidence from the psychiatric panel - from Dr Harris, but the panel agreed - I say that to refresh my friends' memory - that there is a risk - or sorry, I'll come to that. I'll give you some more information in the meantime.

Could I ask that you have a look at this letter, page 788A, 5 April 2018. That notes 5 April 2018, "Best I have seen him." This is of course to Dr Grundy. "Developed new interest in IT on top of continuing with Chinese. Energy is normal. He's happy with a lot of spontaneous brief smiles, apsychotic and euthymic". Euthymic means stable mood?

WITNESS WILSON: Stable mood.

DWYER:

> "Finding it difficult to terminate Clopine. Wants to do it slower, going down from 25 to 12.5 milligrams at night for a month, and then maybe 6.25 milligrams at night for a month, and then stop. Agreed with this plan. Follow up in a month".

The indication from this letter is that Joel is, as it says, doing extremely well, but also, do you agree, that Joel himself is very invested in his recovery? So, whereas the initial plan was 25 milligrams reduction, it's Joel who wants to do it more slowly. So, you've got there someone who appears to be a very compliant and cautious patient?

WITNESS WILSON: Mm.

WITNESS KRUYS: Yes, I agree.

DWYER: The next letter is 12 June 2019. That is, the next letter to show you. I should note that there were regular correspondence. The next letter to show you is 12 June 2019. On this occasion Dr Boros-Lavack advises Dr Grundy that all of the antipsychotic medication will be ceased.

I should say for the benefit of my friends, this appears at tab 788A where there are a number of documents that were initially overlooked in terms of being provided to the Court. So that they're an additional 49 pages.

> "Seen with mum re stopping Abilify 5 milligrams in the morning. Mum agrees that since Clopine was stopped a year ago, her son" it should read, "has become totally well with a remission of his psychosocial disability. Joel has caught up with his development delays and lives independently a happy and good quality of life. The only problem has been his residual complex tics involving his sternocleidomastoid muscle, causing his neck to involuntary turn to the right with occasional facial and ocular grimacing. The plan collaboratively was decided to stop Abilify 5 milligrams in the morning and continue with no psychotropics at all".

He was noted to still be on vitamins and melatonin for sleep. We heard from Professor Harris, one of the five psychiatrists on an expert panel yesterday, that the risk of relapse for persons who have treatment resistant schizophrenia is about 77% in the first year and 90% by over two years. Dr Wilson, is that something that you would be aware of as someone with your expertise as a GP?

WITNESS WILSON: Not as a GP. Once again, this is treatment-resistant schizophrenia having a - using clozapine. You know, as a GP I'd be thinking this is, you know, treatment-resistant. It's, it's serious. But the percentages and times to relapse, no.

DWYER: The very substantial risk of relapse, that is, it's only 10% on his evidence, as agreed by the panel, that don't relapse within a relatively short period of time?

WITNESS WILSON: No, not as a GP. I mean I guess I would be thinking there is a risk of relapse, but I wouldn't, I just don't have the expertise around that, that, yes, what that level would be. I don't know.

DWYER: Dr Kruys?

WITNESS KRUYS: No, I agree. I agree.

DWYER: The--

HER HONOUR: Can I just ask--

DWYER: Please, your Honour.

HER HONOUR: If you did know that, or if it was spelt out, what would you do?

WITNESS WILSON: As his GP?

HER HONOUR: Yes.

WITNESS WILSON: Me, I'd be concerned that he had stopped all of his antipsychotic, and I'd be wanting to follow-up with him. Now that is such a high rate. And certainly, this is a young man who, you know, wanted to stay well.

HER HONOUR: How would you follow up with him?

WITNESS WILSON: I would, I would make appointments to see him.

HER HONOUR: So, you would be proactive?

WITNESS WILSON: Yes, yes.

HER HONOUR: Okay.

WITNESS WILSON: Yes.

DWYER: If your patient was coming to see you about other physical health matters, as Joel did with Dr Grundy, would it be something that you'd then incorporate into your discussions?

WITNESS WILSON: Yes.

DWYER: Dr Kruys?

WITNESS KRUYS: Yes.

DWYER: The next thing to go on the page, if you don't mind, please, is page 22 of those notes. These are the records of Dr Grundy, or additional records. The last letter sent from Dr Boros-Lavack in June 2019 left the impression that Joel was doing very well. On a consultation on 14 March 2019, so just a couple of months before that June letter, there's a note from Dr Grundy, Dr Richard Grundy, "Requests plan to access psychology to get some counselling. Check out options. Will think about this".

If I can ask you to accept this evidence, Dr Grundy's asked to reflect on this by Dr Boros-Lavack many years after the event. Dr Grundy's evidence was that he did not recall that presentation. That's, for the benefit of my friends, 15 May 2025 transcript 1118. It appears that nothing was done after noting that request and saying "I'll check out the options and I'll think about this".

You will have seen in Dr Grundy's notes that Joel comes back for a visit on 29 May 2019 about a cough, and he comes back on 16 August twice in relation to some symptoms of URTI and viral symptoms and being unwell. But there's no further discussion of mental health issues. Does that underscore the importance of the GP and the psychiatrist communicating about the possible risk, given the significant issues around Joel's medication at this stage? Dr Kruys, you're nodding?

WITNESS KRUYS: Yes, I agree. If you were aware of the risks and the symptoms to look out for, maybe you wouldn't just let him get away with thinking about the options, but you would challenge him a little bit and encourage him to take action and to support him and say, "Come back in two weeks' time. If you're not quite sure, we'll talk about it. Here are some names of psychologists you could see". You may have put an active reminder in the system, so you recall him again in two weeks' time.

It's fascinating that he wants to see a psychologist, but something happens and he's checking out his options. It's not followed through. And to me, I'm wondering what is it that he is - what's going through his mind? What is happening here?

DWYER: Dr Grundy should have followed that up, is that fair to say, in relation to having made a note that he'd "asked to see a psychologist to get some

counselling, checking out options, will think about this"? Is it fair to say that Dr Grundy should have taken action to follow that up?

WITNESS KRUYS: That's - that goes about how much responsibility do you give to a patient, how much ownership does the patient have about their health versus how proactive are you as a, as a GP. And I think that in general practice you don't have involuntary treatments, so it is up to the patient to come back often to the GP. But I agree in general, with patients who have a chronic mental illness that a more proactive approach including recalls, care plans, et cetera, is appropriate.

DWYER: Because unlike dealing with somebody who has a condition like epilepsy, for example, there are capacity issues for people who suffer chronic mental health issues, isn't there?'

WITNESS KRUYS: Yes, yes, I agree. But also, I guess--

MATHUR: Your Honour, sorry, it's a belated objection, but I take an objection to that question in general terms.

HER HONOUR: Which question?

MATHUR: That a person who suffers from a mental illness has capacity issues.

DWYER: I'll withdraw it. I'll ask it differently.

MATHUR: They certainly have capacity issues.

HER HONOUR: Sure.

MATHUR: They may have capacity issues at points in time, but to suggest that a man with treatment-resistant schizophrenia has at all times capacity issues is just not correct.

HER HONOUR: The question's been withdrawn.

DWYER: Taking it on that basis that you might have capacity issues if you've got treatment-resistant schizophrenia, and given Joel had experienced the symptoms of treatment-resistant schizophrenia that were positive, negative and cognitive, was it incumbent on the GP to follow this up after he'd asked for a psychologist, Dr Kruys?

WITNESS KRUYS: Can I say in general that any chronic condition, whether it is a mental health condition or a physical health condition, would benefit from a proactive approach from a GP or a primary care team and encouraging patients to come back regularly and encourage them to look after themselves.

HER HONOUR: Just another practical point. I'm assuming Joel wouldn't know where to find a psychologist, isn't that what he's going to the GP to find out, to

get a referral or a name?

WITNESS KRUYS: Yes, correct, yeah. What, what often happens is somebody says, "I want to see a psychologist," and then you say, "Well, what is the problem? What would you like to discuss?" So you can direct them a little bit what kind of treatment.

WITNESS WILSON: Yeah.

HER HONOUR: But it wouldn't be unusual to actually come up with some names, would it?

WITNESS KRUYS: That's right, and quite often patients want a few names and they want to do the research, they want to Google them, they want to see, and then they come back and they say, "I've decided this such and such, can I get a referral there?" That's not an uncommon process.

HER HONOUR: No. Thanks.

DWYER: I take it from your evidence a few answers earlier that if you were a GP who had information that around that time clozapine had been withdrawn, there was a very small amount of Abilify, and in June he was taken off all antipsychotics, and this is a risk within two years 90% of patients will become unwell, 77% of patients will become unwell within a year, does it highlight then, with the patients asking for a psychologist around that time, that you need to be more proactive, that is, if you understand the risk, you're likely to be more proactive?

WITNESS KRUYS: Yes, I agree.

WITNESS WILSON: But it's also, this is also in the context of understanding that the psychiatrist was continuing close follow-up.

DWYER: Yes.

WITNESS WILSON: What is the role of psychology? You know, so that might not specifically be related to his medication or his, his stability for his schizophrenia. I, I think it's - yeah, I just, I just worry that it's easy to look back and go now that we know that it's this 70 to 90% risk of relapse and he was asking for a psychologist, that we would do things differently. And, and, but, and certainly my understanding of Joel was he was very compliant, he was very engaged in treatment, he was cautious, he wanted the best outcomes. And, and it's that balance between supporting people to get the care they need and, and being somewhat directive but also allowing autonomy.

DWYER: Yes, but given the brevity of the note there from Dr Grundy, it's not clear what Joel was asking for psychology for.

WITNESS WILSON: Yeah. Yeah.

DWYER: And at that time he was on a very different medication regime as at March 2019 than he had been when he'd been discharged from the public sector on a high level of clozapine with a high level of confidence.

WITNESS WILSON: Yes.

DWYER: As he would. I just suggest to you that it underscores exactly what you've said so far, that there needs to be much better communication between the general practitioner and the psychiatrist if the general practitioner is to play any role in monitoring the mental health. I think you both agree with that?

WITNESS KRUYS: Yes.

WITNESS WILSON: I think if I had a letter from the psychiatrist saying, "Please refer this person to psychology," then I would probably push it a bit harder because it's actually coming from their, their specialist. Once again it's the, the history of the lack of involvement of the GP that, you know, really the only thing that GP was asked to do was to do yearly echocardiograms and we refer.

DWYER: Just in relation to this, though, we've got Mi-Mind writing regular - when I say Mi-Mind, Dr Boros-Lavack primarily - writing very regularly to Dr Grundy saying that Joel was doing well. And within Mi-Mind we've got mental health nurses, a sexual health specialist psychologist, and more than one psychiatrist, but there's no evidence of Dr Grundy writing back saying, "Joel has requested a psychologist." Does that suggest that the information flow wasn't optimal?

WITNESS WILSON: Clearly the information flow wasn't, wasn't optimal.

DWYER: On both sides on this occasion?

WITNESS KRUYS: Yeah, I think it's a two-way thing. If you look at the letters back to the specialists, they're also very brief and they are not really outlining - and, and I would, I would ask what is it that the specialist needs from the GP, and if you have that clarified, you get a much better collaboration. Same like the GP needs to have certain information from the specialist. It goes both ways.

DWYER: Which goes back to your original point, both of you, about the sorts of things that Dr Kruys outlines at paragraph 24 needing to be very clearly spelt out at the beginning.

WITNESS KRUYS: Yeah.

WITNESS WILSON: Yes.

DWYER: Just going through again chronologically, from that period of time in June 2019, there are a number of things that happen that are witnessed by Mi-Mind staff but I'll take you to March 2020. Dr Grundy received a letter from

Dr Boros-Lavack dated 19 March that year advising that Joel was no longer in her care. If that could come up on the screen, it's page 48 of tab 788A. I think when you first received the bundle of documents to prepare your expert reports, this letter was not provided and there's a query about whether any discharge letter was received. We know that Dr Grundy has acknowledged that this letter was received. This has been the subject of some questioning already in the inquest but I note that it says:

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

Just as a reminder, Joel is taken off his clozapine in June 2018, he was removed from all antipsychotic medication, that is the Abilify, three months earlier. Given Joel's history and Dr Grundy's history with him and that letter, Dr Wilson, what was the expectation of a general practitioner on receipt of that letter?

WITNESS WILSON: Say it again?

DWYER: What was the expectation of a general practitioner in Dr Grundy's position on receipt of that letter?

WITNESS WILSON: So on, on receipt of that letter, I think that it's a little unclear, the letter is not, not clear, and given the history of, you know, really a very passive involvement in the mental health care, I mean, it does say, you know, "recall if required" - sorry, I'm not, I can't see the letter, if we could pop it back up again?

HER HONOUR: Maybe we should get the letter up again.

WITNESS WILSON: Yeah, yes.

HER HONOUR: It's important, the wording.

WITNESS WILSON: Yeah, yeah. So, "Please recall Joel to discuss his options and, and referral to an alternative psychiatrist if required." Is the recall required or is the referral required? It, it's, it's not - it is a little bit open to interpretation. I - it does seem very precipitous, you know. "Okay, so he can't see me, so he's going to come and see you," and yet the GP is also in

Toowoomba, how is the patient going to get back and see the GP? And, and just, yeah, I - it does say "recall". Ideally, you know, as a GP, you would have tried to get in contact with Joel to follow up, but I can understand why it might not have happened, given the, given the, that it's not entirely clear.

DWYER: Before I come to Dr Kruys, how much clinical information does that provide you with?

WITNESS WILSON: And, and this is on the background of Dr Grundy believing that Joel had been doing very well, you know, and been, been very well post stopping his medication, so it, it, you know, potentially it's, "Well, he's doing well. If he wants to come back, he can, he can see me and I'll have a chat to him and refer him if required," could be an interpretation.

DWYER: Dr Kruys, do you have a comment on the actions of Dr Grundy after that time? Dr Grundy's evidence is that he did not recall Joel, and I'll tell you his specific evidence shortly, but just in general, what's the expectation on him at that stage?

WITNESS KRUYS: So, so I think that in general, it is good practice to consider recommendations requested by specialist colleagues. I, I think as the GP, you have the overall responsibility of the care, even though you give part of that responsibility to a specialist when you refer. You remain as the GP having that overall responsibility at the end of the episode of care with the specialist. Mr Cauchi's a vulnerable patient, there's a risk of relapse, associated health risk, a chronic condition, so there is an expectation I think to recall the patient at this point.

However, there are few considerations and that is indeed, as already has been said, there's minimal, has been minimal involvement in the mental health care and suddenly the GP is being asked to make decisions about that care, whereas he has not been involved in any decisions over the past few years. He was also not fully informed. We know that there was a lot more happening than is visible in this letter. And I would argue although this is a, this is a discharge letter, it is not a clinical handover letter, and as such, Dr Grundy would not have been in a position to make a fully informed decision.

HER HONOUR: But isn't all he's being requested to do is to discuss options, and I don't know whether that's meant to be discuss options and referral to an alternative psychiatrist if required. I mean, there's some evidence from Dr Boros-Lavack that what she meant was "if required" meaning if he didn't go back to see her. But it's not like it's a request to make any complicated specialist decision about his psychiatric care. Isn't it just to what happens next?

WITNESS KRUYS: Yeah, and what happens next depends on how he is struggling. Is, is he stable? Is he - what are the concerns? What are the risks? What, what - are there any early warning signs?

HER HONOUR: But wouldn't it be general knowledge to know - I think you've

mentioned it before, Dr Wilson, it was in some of the correspondence before that was up on the screen - that there's going to be a need for long term care, follow-up? There's always a risk of relapse for someone who has a serious condition that he had. Wouldn't that be just general knowledge for a GP?

WITNESS KRUYS: Yes.

WITNESS WILSON: Yes, it would, but I, I guess I'm thinking about all those letters that came to the GP that was saying, "Doing really well. Stopped his medication. Been well for a year." It's, it, it, it creates a more complex picture, you know. If you just take that bit of information, you know, "He is at risk of relapse and will need long term medication," out, but what we've got is the whole kind of trajectory of how well he was doing that was expressed in the letters.

HER HONOUR: But the other thing to bear in mind is that Joel had been seeing Dr Grundy for 18 years at this point. Is there any responsibility to do something when asked to recall--

WITNESS KRUYS: Yes, yeah.

WITNESS WILSON: Mm.

WITNESS KRUYS: And that's why I say Dr Grundy remains overall responsibility, responsible for his care, so the episode of care with the specialist has not finished, so there is a responsibility for Dr Grundy to take action, and that's what I started with, but I'm just giving some considerations that it is not as straightforward as--

HER HONOUR: No, of course not.

WITNESS KRUYS: Yeah.

DWYER: Dr Grundy's evidence, for the benefit of my friends, transcript 15 May 2024 at 1126.39 is this, I asked him a question:

> "Q. Are you able to say why you did not recall Joel when you received the letter?
> A. At the time I thought Joel was well. I thought he'd taken himself to live in a different city, which was his right to do. He could return to the practice any time he liked. I don't think, when I look back over my years of practice, I've ever recalled or chased someone up who was living in a different city to get them to come back and see me.
>
> So I'm not sure exactly what Dr Boros-Lavack expected of me there. Joel was always a person who had made his own appointments if he had any concerns about his health issues. I would think whichever city he was living in, he would have contacted a GP for assessment and referral as required, or they'd make that referral. So unless there was some sort of outstanding pending results or

> I had some information that his mental state had deteriorated, I didn't have any information, all those things were discussed for some reason or other, never came to me. All those phone calls from his mother, from his family, I had none of that, other than my memories of Joel when I saw him in 2019 and he was well."

Dr Wilson, do you have a comment on that explanation?

WITNESS WILSON: Yeah, I think once again it goes, goes back to the, to the, to the information that Dr Grundy had in his experience of Joel, and, yes, he had been seeing Joel for, you know, many years. However, he'd seen him for intermittent, you know, occasional general health stuff, and had done a few investigations, as requested by the psychiatrist, but really hadn't been involved in, in the management of his, his chronic mental health. I mean, it's, it's a missed opportunity once again, and, you know, I'd like to think that if I got that letter that I would do something.

But it's, it's just not clear, you know, and that's, I guess that's the thing; would be can we, can we shift this so that there's communications and that safe transfer of care, or handover of care, it, it has really clear roles and responsibilities, you know, that, that really help us to go, "Okay, so it's really clear I need to do this", you know, "so, I will, I will get my receptionist to get, give him a call and book an appointment."

DWYER: And a handover would, if there was a clear indication of what was required, one of the subheadings would be "Recent red flags" or "Early warning signs"?

WITNESS WILSON: Exactly, cause there's, there's no clinical information in, in that letter. It's a, "I can't see him anymore cause he's moved, and I can't get Medicare", which is fair enough. But it doesn't - it's not actually really - it's not an adequate letter for the safe handover of care.

DWYER: You both have said to me outside the courtroom, and again, when you first started giving evidence, you would very much like to see this understood as not a discharge letter, but a handover, so we need to change the terminology here when you're managing chronic patients?

WITNESS WILSON: Yep.

DWYER: Can I just ask you, before I move on from this issue, as you know, there's a dispute between Dr Boros-Lavack and Dr Grundy about whether or not this letter was followed up with a phone call. Dr Grundy says it wasn't followed up with a phone call, and if it had have been, he would've made a note in his records. There's no note in his records or Dr Boros-Lavack's records, but she gave evidence that she recalls a phone call, and she said this on 13 May transcript, 975.

She recalled calling him, and she said, "I said unfortunately I wanted him to follow up, but there was no rebate and he, Dr Grundy, totally understood." And

she said to him, "'Can I send it back to you?', and he said, 'I'm the family GP. I know him very well, and I will recall and I will do my best.'" She gave evidence, "That's what he said. He could deny it. I can tell you, and don't believe, I take" - so, she says she did recall and he was happy to take Joel back.

LYNCH: As for that premise, it needs to be qualified in relation to the answer that, I think, was given by Dr Boros-Lavack, in answer to my friend, Ms Mathur's questioning that she wasn't sure of the content of the call. It was raised the other day, but the same qualification to the original evidence about the content of the conversation was clarified, so that it was left on the basis that she wasn't quite sure of the content. And I think--

HER HONOUR: Yes.

LYNCH: --qualified it, at least.

DWYER: If you assume then that the evidence is unclear, Dr Grundy denies that there was any call, Dr Boros-Lavack says there was a call, she initially recalled the content to the extent to which I read to you, and then later, as my friend says, said that she didn't recall the content of the phone call, if there was a follow up call from Dr Boros-Lavack with any content, would that change your view?

WITNESS WILSON: Yeah, so if the psychiatrist had contacted me, as a GP, and said, "Look, this is what's happened. I need to discharge him from my care. He will need further follow up", you know, and the, and had explained the concerns that she had for his ongoing care, absolutely.

HER HONOUR: And there's also an option for Dr Grundy to have contacted her, to get clarification?

WITNESS WILSON: Yep, absolutely.

HER HONOUR: Is that something you would expect, if you were not sure, if you're uncertain about--

WITNESS KRUYS: Yeah, I can certainly, if you get a letter to discuss the options, and I don't know what the options are.

WITNESS WILSON: The options are.

WITNESS KRUYS: And if required, and - well, "Well, does he need a psychiatrist referral or not?", I might just pick up the phone or send a quick letter to her, "What is it exactly that you want to do?" That's easier said than done, if you have a lot of patients and you're running an hour late, and there's angry patients in the waiting room.

DWYER: Just before I leave the discharge from Dr Boros-Lavack at that time, can I remind you of what was alluded to in the evidence of Dr Grundy about

what he didn't know. The last notation, as you know, 12 June 2019, from Dr Boros-Lavack, the last letter suggested that Joel was extremely well. In September of 2019, Joel was noted by the Mi-Mind clinic to not be sleeping as well, although he was easily engaged. He had complex tics at that stage still, with the sternocleidomastoid muscle, facial and ocular grimacing.

On 17 October 2019, Dr Boros-Lavack saw him with Nurse Brooks and mum for the first time, in all the years that she had seen Dr Boros-Lavack, noted that she had concerns for Joel's relapse. She called the admin and she reported her concerns for Joel's mental health and physical health. Joel had tried to cancel an appointment with Mi-Mind, and his mother told him to keep the appointment. On 12 November, Joel wrote an email to the Mi-Mind clinic, saying, "Can we please cover some ideas for a porn-free phone and other devices on Thursday?", when he was seeing Dr Boros-Lavack.

He said, "I will consider a porn-free ISP, if the cost is reasonable as well. I'm seeing a specialist, if that's what you recommend. I want a totally porn-free internet on my devices, if possible, on all browsers and potential browsers, on images too", he goes on to mention. So, he's concerned about that. On 14 November, when he sees Dr Boros-Lavack, there is a discussion of those concerns, and some advice about how to remove access on your phone is given. On 20 November, there's an email from Michele Cauchi, Joel's mother, to Dr Boros-Lavack directly saying she's contacting her about Joel:

> "He isn't doing very well since going off Abilify. And I know that you thought it wasn't having any effect, but I have noticed a gradual decline in his condition, and judging from notes on paper he's left around the place in the past week, I have a feeling he's now hearing voices. He's 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, has put someone new on, and he was hoping to get a job there, so that was a real blow. I would hate to see him having 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 it's the clozapine that did that, not the Abilify."

She says. "He's also 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", Michele tells Dr Boros-Lavack.

> "I would appreciate if you wouldn't tell him I've contacted you, as I don't want him cutting off communication with me, as I'm the one who looks after him when he needs it. I would like to see him being able to live successfully independently, and doing as well as he was a year ago, when he moved out of home."

Before, I asked you a question about that information. I note that the same

day, 20 November, Nurse Brooks writes up in her consultation notes:

> "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 in the shower. Writing a lot of notes, plus, plus, plus, at home and leaving them about. Mother read some notes with content of satanic control, of religious themes, desire for porn with conflicts of his religious beliefs. Leaving his phone with his mum at night so as not to use the phone and internet for porn sites.
>
> Mother reports he is walking funny, change in his gait. Is afraid of getting sick and wearing layers and layers of clothing. He's been observed that he bends his head a lot and has odd movements. The Mi-Mind office staff noticed an unusual presentation, where he asked for coffee and drinks and he's never done it before. That same day when the nurse saw him, she noted he had poor eye contact, was evasive in direct answering questions, had long replies, only vaguely answering questions.
>
> He was cooperative and friendly, and denied hallucinations. But he was noted to have difficulty explaining himself. He repeated his words. He speaks slowly. He deliberately had no substance for topics. He skirts around the issues. He was preoccupied. Not expansive. Denied themes. He was excessively tired."

And on that day, a suggestion was made by Dr Boros-Lavack that he resume antipsychotics, Abilify. If that information that should've been passed on to a general practitioner who is expected to have some involvement in his mental health care?

WITNESS WILSON: Yes.

DWYER: Dr Kruys?

WITNESS KRUYS: Absolutely. These are red flags.

WITNESS WILSON: Yeah.

DWYER: Does your opinion change if Joel was then seen by Dr Boros-Lavack a week later and, in her note, she says she saw him with a nurse, mum was contacted by telephone, who told Joel to restart Abilify for relapse prevention, based on his early warning signs of relapse; "Joel presented well today. Feeling good with sleep and no fatigue. Going to Caloundra on holiday. Not keen to start Abilify", and, in those circumstances, she gave him Rexulti, an alternative drug to start if he, Joel, noticed the symptoms. Should that information still have been passed on to the general practitioner?

WITNESS WILSON: Yes.

WITNESS KRUYS: Yeah, absolutely.

DWYER: Why do you say that, Dr Kruys?

WITNESS KRUYS: Well, I mean, these are red flags indicating that there is something happening, and then, a week later, suddenly there's an improvement, and there's a standby medication offered to the patient. Sometimes patients contact their GP, and they say, "Well, the specialist has given me this or that. What do you think I should do?", and then there's an opportunity to encourage a patient to take those medications. Or you could take it even a step further and you could actively recall the patient, or make a phone consultation, while he's on holiday or when he gets back, depending on how proactive you are as a GP.

HER HONOUR: Would you really do that if he was seeing a specialist, if he's seeing a psychiatrist? Like, why would a GP do that, if he's under specialist care of a psychiatrist?

WITNESS KRUYS: Because you are their family GP and you look after them for many years, and you often are involved in the, in the care. You have a responsibility for the patient.

HER HONOUR: I understand that and that's the conversation we were having about the request to recall Joel.

WITNESS KRUYS: Yeah.

HER HONOUR: But this is about specialist care about dosage, and--

WITNESS WILSON: And given the--

HER HONOUR: What could a GP do?

WITNESS WILSON: Given the history that the GP really hasn't been involved, and has been informed along the way, and it's--

HER HONOUR: No, it's not really shared care, is it?

WITNESS WILSON: It's not really shared care and, once again, it's a missed opportunity that could've--

HER HONOUR: I don't think it was ever set up as shared care, was it?

WITNESS WILSON: No, no.

DWYER: There's information in the Mi-Mind notes on 21 November that although Joel's mother was raising these concerns and very much wanted her son to go back on the antipsychotic medication, there's a call to Joel's dad, and I mean this with no disrespect to Andrew Cauchi, who battles with his own mental health issues and clearly loves his son and tried to help him, but:

> "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."

Dr Grundy saw Mr Cauchi Senior, Andrew Cauchi, for a lengthy period of time. Andrew Cauchi continued to hear his own voices, including demons, and that was part of the psychosis that Joel had experienced. Was there a role for the general practitioner, Dr Grundy, to play in educating dad about the risk for Joel around this time, if he'd been informed of this?

WITNESS WILSON: Absolutely.

DWYER: Dr Kruys?

WITNESS KRUYS: Yeah, I think psychoeducation of the patient and the family is part of the role of the GP to support specialist care.

DWYER: So can I come now back to the time of discharge, or what we prefer to call handover, but was, in effect, a discharge, where Dr Boros-Lavack said, "I'm not seeing Joel anymore", in March. Can I ask you to assume that Joel had been seen weekly, for about three weeks, by the Mi-Mind nurses after these concerns were raised by his mother. That the evidence from Dr Boros-Lavack and the nurses is that they took mum at face value; that is, that they accepted that she had read these notes and they had satanic content and that she was very concerned.

The evidence of the two Mi-Mind nurses is that they wanted Joel to start this medication again. The evidence of Dr Boros-Lavack is that by the time of discharge, she had convinced herself, she remains convinced, that Joel, in fact, was not sick and that this was a false alarm. On 14 February, Joel's mother called to express her concerns again about Joel's functioning at home. So in spite of the fact that Dr Boros-Lavack and the nurses had not after November noticed themselves any signs of hallucinations, she reports she's already got concerns about Joel's functioning at home and his probable move to Brisbane. "His self-care is poor. He appears isolated, and he is occasionally swearing." And she talks about him being irritable.

Dr Boros-Lavack did not see him again in person after that time because of COVID and other issues, but he was seen on Skype on 17 February and she noted him to be well-groomed, good hygiene with no tics, mentally good. And so the plan was for continued support, monitoring and support, no meds, follow-up in a month. And then on 16 March the appointment was cancelled because Joel had moved out of the area.

Dr Grundy gave evidence on 15 May that if he had been told in a letter or by phone call that from October 2019 through to February 2020, Joel's mum had contacted the practice and expressed those concerns that I've read out to you, that his mental health was declining after he was weaned off medication, and that his mum was concerned that he was hearing voices, that he would have

followed that up. He said that if he'd been told that, he would have been concerned to make sure that Joel had a psychiatrist going forward. What's your view of that Dr Wilson?

WITNESS WILSON: Absolutely agree, you know, and I, and I think perhaps as general practitioners we're used to seeing families and, and having conversations with carers and, and family members and trusting what they say. You know, I know if I see someone for 15, 20 minutes, maybe a little bit longer, I have a little snapshot of them. But, but carers or family are with them long, long term, and will, will know things that are - you know, and, and observe things that I just can't. You know, and, and, and we know that Joel did minimise his symptoms, and perhaps was, you know, lacked the understanding of those symptoms at times.

And so taking the mum's, you know, understanding the mum's concern and taking that seriously, you know, would - it, it gives it a very different picture to the letters that we have had from the psychiatrist who says everything is, is going well, he's symptom-free. And I, I - the idea that it was a false alarm with, with mum concerned, I'd, you know, really be wanting to make sure that he was, he was receiving care.

DWYER: Dr Kruys do you have anything to add to that?

WITNESS KRUYS: Yeah I guess the opinion of family and friends around the patient are very important to paint that picture of how somebody is actually travelling.

DWYER: Joel's mum had expressed a number of times that she didn't want Joel to cut off communication, so she didn't want Boros-Lavack raising with him that she had been the one to communicate that. How could a GP raise that with a patient in those circumstances?

WITNESS WILSON: It, it, it's not uncommon for family members to say, "Look, I'm telling you this, but please don't say - don't - please don't tell them." And it does put you in a tricky situation, and the way that I would respond to that is, look, "I'm, I'm not going to tell them, but if they ask me, 'Did mum tell you such and such", I, I'm not going to lie."

DWYER: Mm.

WITNESS WILSON: "But I'm not going to bring it up." And, and we're very good at saying, "How's it going", you know, "We know you've had these, these issues in the past." We don't need to say what mum told us. We're, we're very, we're very used to keeping containers of information in, in families and maintaining confidentiality when it's needed.

DWYER: But it would make you more proactive without having to reveal that information--

WITNESS WILSON: Absolutely, absolutely, yeah.

DWYER: We know that around this time, Dr Grundy was the GP who saw Joel most frequently. Joel also saw other GPs when he was not available or for any other reason. So if I could just have 788A again at page 23. You can see there a visit to Dr Susan Dragone, who was one of Dr Grundy's colleagues, from 21 November 2019.

So if you put that in time - if you understand what's happening around that time, if you had the information that Dr Boros-Lavack had, this is when Joel's mum is writing that email. It's a couple of weeks after Joel himself has written, saying he's really worried about his access to porn. STI screen - he'd had sexual intercourse with a sex worker and used a condom, but he'd never had an STI before. So she arranges an STI screen for him, and 25 November that screen came back negative. So there were no concerning results, discussed retesting in three months' time, around the time that Joel was leaving the area. Then there's a note from 25 November from Dr Dragone again:

> "Requested by reception to call Joel again after this appointment asking about a medication to prevent getting STIs. I explained there's no medication for this and using condoms is the best protection, also asking for a referral to Queensland Fertility Group for semen freezing. I asked why he would like to freeze his sperm, and he says that he wants to make sure it's available for a future use. I explained that he could still make sperm well into his later years, and unless he's undergoing chemotherapy or radiation he is not - does not need to do this and it's very expensive. Joel still wanted that referral."

Dr Kruys, I think you comment on this, in that in the context of Joel's chronic illness it's a strange request. Do you agree?

WITNESS KRUYS: Yeah it's something that again you are, you are thinking, "What's going on in his head? What, what's the reason that he asked this?" And I don't understand that. And if I don't understand a patient who has a history of a mental health condition, there are question marks popping up about relapse or a worsening.

DWYER: On 28 January 2020, Joel had a communication with the Mi-Mind Clinic, it's page 19 of tab 793. I will read it to you, it's - while that's popping up. 28 January, "Snez" - if I could ask you to assume that's another psychiatrist, Dr Snezana - "advised that Joel had sent her a message on Skype saying, 'Do you have advice on men's sexual performance?'" And that advice was given, that is, the fact that he had sent that text message was given to Dr Boros-Lavack.

Dr Kruys, do you have a comment on this? In terms of information sharing, this piece of information was not passed onto Dr Grundy, and it doesn't appear that the information in relation to Joel wanting fertility testing or to preserve his sperm was passed back to Dr Boros-Lavack. Does it appear to be a red flag in the context of Joel's chronic schizophrenia, having been taken off his

medication three months' earlier?

WITNESS KRUYS: So that, that would be speculating a little bit. Because I - again I wonder, what is - why is he asking this? What's going on in his head? What are his concerns? Are they realistic concerns or is this part of a mental illness? And that's not been explored. So it's really hard to say. If he is really concerned about his sexual health, then it's definitely something that can be handed over or he could be referred to his GP to further discuss. If it is part of a delusion or a psychotic symptom, then it is for the psychiatrist to follow up. You could still argue, as we've said before, that it is good to keep each other informed about what's happening.

DWYER: In circumstances where there's such a high risk of relapse when you take somebody with Joel's condition off antipsychotics and then just three months afterwards he starts to display symptoms, and then right up until the time where he is discharged and leaves the Toowoomba safety net, there are significant red flags aren't there, when you put them all together, that suggest he is becoming very unwell around that time of leaving Toowoomba. Do you agree Dr Kruys?

WITNESS KRUYS: I agree, yes.

DWYER: Dr--

WITNESS WILSON: Yes, yes.

DWYER: --Wilson? And all this just underscores the need for very careful planning for continued care for a patient in Joel's condition. In relation to his concerns about - sorry, you nodded. I'm just reminded that we just need to record the fact that you are both in furious agreement.

WITNESS KRUYS: Agree, yes.

WITNESS WILSON: Yes.

DWYER: Around - in relation to sexual functioning, what we go on to see, in 2022 in particular, is that Joel was accessing pornography and very concerning content at an increased level in 2022, and in fact there's a very concerning attempt to visit an all girls' school, and he makes contact with that school, and fortunately they then pass on that information to Crime Stoppers. What we know, that one of the triggers for worsening schizophrenia is stress. And in these circumstances, when Joel had been so compliant and had wanted to stay well and was reaching out for help in relation to dealing with the compulsion about pornography, it was essential to wrap around supports for him, wasn't it, for his benefit and for the safety of the community, in relation to him wanting access to sexual connection? Dr Kruys?

WITNESS KRUYS: Yeah, absolutely. If you, if you put it all together, then you would say, this is a time where somebody needs more support, more, yeah, as you say, wrap-around care. The GP needs to be involved, maybe a

psychologist as well. Medications would have - need to be reviewed by the psychiatrist. And it is sad to hear that that hasn't happened.

WITNESS WILSON: And it's, it's the level of distress that this, this flags, and, and you know certainly, absolutely, people, you know, health professionals being involved and medication being reconsidered, because it just feels like it's this, this slow decrease in function and, yeah, becoming very, very unwell.

DWYER: Can I suggest to you that part of the tragedy of this is that when you look at what happened on 13 April, it's horrendous and the tragedy is unfathomable, but part of the tragedy is that this man wanted to stay well?

WITNESS WILSON: Yes, absolutely.

DWYER: Can I suggest to you that he was really let down by the system of mental health care that he was offered in Queensland, that in spite of the fact that people did well to care for him over many years, at the point when he was discharged from Toowoomba he was really let down, and so were his family, and so was the community? Do you agree with that Dr Wilson?

LYNCH: Your Honour--

WITNESS WILSON: I do. I, I do--

LYNCH: --I object to this question. I mean these are GP experts of some eminence--

HER HONOUR: Yes.

LYNCH: --but this question is really either a self-evident part of the tragedy, but your Honour doesn't need to hear the views of these experts in relation to that.

HER HONOUR: Well it - and I mean there were several other doctors that Mr Cauchi saw in the intervening four years as well, so are we asking about whether he was let down--

DWYER: My friend misunderstands the question. It's a systems issue. This system--

HER HONOUR: But you're only talking about from the time he was discharged, but I think it's the whole period up until--

DWYER: I include that whole period in the question, and I'll repeat the question if I may including that period. If you understand the trajectory of what happened to Joel after that time, including what I put to you about his declining, or - I withdraw that, including what I put to you in relation to his access in 2022 to pornography and extreme content that was violent, do you agree that he was let down by the system in terms of not being followed up?

ROBB: Your Honour, it's a very, very difficult question.

HER HONOUR: I think it is.

ROBB: It interacts with human rights issues, patient autonomy, clinical thresholds with respect to capacity that have not been explored and are not in evidence and are not able to be established. It's an opinion that in fact is not meaningful from these experts. I don't know what--

MATHUR: And I share the objection because part of the system were other GPs who saw Mr Cauchi, and in more - there's roughly 30 points of contact with Mr Cauchi by general practitioners, by Queensland Police officers and by two psychiatrists. So to ask a question in those general terms and circumstances where their individual conduct has not been under any criticism or scrutiny in this line of questioning in my submission is simply an unfair question.

DWYER: I'll deal with it by way of submissions, but I can foreshadow that as a submission. Panel members, the information that I just provided to you in relation to what was known by Dr Boros-Lavack, in terms of the decline that was noted by his mother, and the concerns that she had about hearing voices, satanic content, thought disorder, decrease in ability to care for himself, do you say that information should have been provided to Dr Grundy at the time that she purported to hand over to him? Dr Kruys?

WITNESS WILSON: Yes.

WITNESS KRUYS: Yes.

DWYER: That information was critical, wasn't it, for anybody else who went on to care for Joel from that period through to the events of this tragedy on 13 April, correct?

WITNESS WILSON: Yes.

WITNESS KRUYS: Yes.

DWYER: In the evidence that you reviewed, could you see any sign that that information was ever passed on to any other clinicians?

WITNESS KRUYS: No.

WITNESS WILSON: No.

DWYER: It meant, didn't it, that other clinicians were operating without the benefit of essential information to be able to provide adequate care for Joel, is that true, Dr Wilson?

WITNESS WILSON: Yes.

DWYER: Dr Kruys?

WITNESS KRUYS: Correct.

DWYER: Can I come then to Dr Ruge? Given the time, I'm just going to rely on your written reports for Dr Ruge, but might I come to the last doctor who had any contact which was Dr Nathan(as said) Pietsch? Can I have on the record the Mi-Mind clinic notes, tab 810 page 10? Sorry, just bear with us. The document that's coming up on the screen is a letter from Dr Boros-Lavack to Dr John Pietsch. The enclosures are four GP letters, and they are GP letters, if you could take it from me, which include - or they were four different dates, 12 June 2019, 1 June 2017, the letter from Nicky Stephens, and the 2012 initial letter from Dr Boros-Lavack to Dr Grundy.

So that letter says, "Dear John, thank you for your recent request for information relating to Joel who I last consulted with in April 2015. I attach four GP letters which I hope will address your questions."

The last letter, if you could just scroll down, was in relation to stopping all antipsychotics where Dr Boros-Lavack says, "Seen with mum re stopping Abilify. Mum agrees that since Clopine was stopped a year ago, her son has become totally well with remission of psychosocial disability," et cetera, that was a letter you saw earlier. And then that letter to Dr Pietsch on 16 November 2023 says that Dr Boros-Lavack last had contact with Joel in April 2015. Now that's obviously a typographical error which is countered by the letter from 15 June 2019. Is that sufficient information in any way to give Dr Pietsch an idea of the sort of follow-up that someone with Joel's treatment-resistant schizophrenia required?

WITNESS KRUYS: It, it--

DWYER: Dr Kruys?

WITNESS KRUYS: Yeah, it misses again the complete picture and, as we've outlined before, the discharge letter is not a clinical handover letter, for example, outlining periodic review or recommendations for ongoing care in general practice.

DWYER: The failure to identify any of the symptoms that his mother had identified is in stark contrast to the letter of June 2019 which suggests that mum agrees that since Clopine was stopped a year ago, her son had been totally well with remission of schizophrenia. So it misses that crucial evidence from mum and misrepresents--

WITNESS WILSON: Yes.

DWYER: --mum's opinion, do you agree, or it--

WITNESS WILSON: We just don't--

DWYER: --misrepresents mum's assessment.

WITNESS WILSON: Yeah, sorry, we just don't have all the information that we need. It, it, you know.

DWYER: Do you have any of the information you need to indicate to the GP what the risk is at that stage?

WITNESS WILSON: No.

WITNESS KRUYS: I don't think that is clearly spelled out in the communication to the GP.

DWYER: Can I come in the--

WITNESS WILSON: Is--

WITNESS KRUYS: With, with the exception of the letter of Nicky Stephens but that's a very old letter, I might add, at this stage.

WITNESS WILSON: Yeah, and that wasn't sent to Dr Pietsch.

DWYER: I'll move on to recommendations. I think that we have clearly outlined the failure of communication issues that have arisen in this case that meant that Joel did not get adequate care at different times. Dr Kruys, you have nominated certain information that should be provided at handover, and I understand that you're prepared to help us to draft some sort of guideline that would be then implemented to assist GPs and psychiatrists in this regard?

WITNESS KRUYS: Yeah, I, I'd be happy to, and I think we need to - there is a need to know what information do we exchange between general practice or primary care and specialist mental health teams, what, what is needed to provide safe care at both ends, so that could be a minimum dataset or a minimum points of clinical information, like relapse, risk, or suicidal risk, for example. But I think there's also a need to better outline the role and responsibilities of each party in primary care and in secondary care, and that starts at the point of referral, what information needs to be handed over from the GP to the specialist team, that goes on during the episode of care.

At what point do we inform each other, for example, if there's a significant change in management or significant change in a clinical condition. And that then ends with the end of the episode, the discharge, what is the role and the responsibility when the care is handed back over to the referring GP and what happens next? And, and although there are lots of guidelines that tell GPs what they need to do for mental health and what psychiatrists need to do, what is missing is that cross-sector collaboration because, as this case clearly outlines, information is very siloed and fragmented and, and I think the next generational guidelines need to better connect our healthcare system.

DWYER: Dr Wilson?

WITNESS WILSON: Yes, I, I, I think this is a really important process and, and myself and Dr Kruys would be very happy to be involved in it, however, I think it would be good for it to sit under the auspices of the College of GPs, of the College of Rural and Remote--

WITNESS KRUYS: Medicine.

WITNESS WILSON: --Medicine, you know, with our mental health services, so that it's actually something that engages with the, the organisations and, and a large group of people that are involved in this. There is - there's good information out there, there's a lot of research that's been done around what is good handover, and I, and I guess I, I worry that, that having something that comes from us is two people rather than a, a kind of systems-wide agreement, let's - and, and, and, and I certainly agree that we see it's kind of overriding principles which are important, but the nitty-gritty of how do you do this, how do you, you know, can we, can we set up a proforma that works, you know, and, and that that would, there would be a process that, that engages with those organisations to do that.

DWYER: The College aren't represented here at the bar table but we will certainly engage them in that process and send that protocol to them for consideration and assistance. Just one final topic so that I sit down. I think that you're both very supportive of the recommendations made by Professor Nielssen and his colleagues with respect to the need for better short-term accommodation options for people with schizophrenia and better long-term accommodation options such as Habilis that Dr Nielssen has been responsible for.

WITNESS KRUYS: Yes.

WITNESS WILSON: Absolutely.

DWYER: The final topic then was one that was raised by Dr Large who provided a report at the request of Dr Boros-Lavack. He and his colleagues raised the issue of the link between cannabis use and schizophrenia and that there is a lack of understand amongst some people in the public. Dr Kruys, are you seeing those issues in relation to the patients you're caring for?

WITNESS KRUYS: Yeah, I, I think cannabis is a major issue in mental health and also medicinal prescribed cannabis often by prescribers in isolation without thorough knowledge of previous mental health histories, and we see a lot of mental health exacerbations as a result of the cannabis happening at the moment.

DWYER: Have you seen any exacerbations as a result of medicinal cannabis being prescribed?

WITNESS KRUYS: Yes, yeah, I, I have. I have seen patients with psychosis as a result of prescribed medicinal cannabis, unfortunately, and it is not a rare

thing.

DWYER: How many are you able to estimate?

WITNESS KRUYS: I would say probably on a weekly basis, there are flags around worsening or patients with a history of schizophrenia or psychosis who have been prescribed medicinal cannabis, and this is in my role in a mental health outpatient clinic, so every week at the clinical handover, cases like this come up.

DWYER: Does that suggest a need for better guidelines in relation to the prescribing of medicinal cannabis so that--

WITNESS KRUYS: Yes.

DWYER: --there's a full history taken--

WITNESS KRUYS: Yes, absolutely.

DWYER: --and understanding of the vulnerability to mental health issues?

WITNESS KRUYS: Yes, absolutely, and, and I think those prescribers need to be better connected and with the wider healthcare system and be aware of the risks, and also there are very narrow indications for medicinal cannabis and it appears, based on the anecdotal evidence, that we are seeing that those indications are currently broadened and that it is prescribed for other reasons where there is limited evidence for.

DWYER: Dr Wilson, do you want to add to that?

WITNESS WILSON: Yeah, I, I don't think we have good data on the prevalence of exacerbation of psychotic symptoms from medicinal cannabis, but it is certainly something that, that our, our colleagues are seeing. I - it, medicinal cannabis is still an experimental medicine, it has not been approved by the TGA but it has been provided and it can be very useful for some people and, and, and be very positive for some people. I - we do have issues with standalone asynchronous cannabis companies who are pushed a certain product and, and the risk there is that there is harm that comes from those poor clinical practices.

I would, I would hate to see a pendulum swing that actually stops access to medicinal cannabis for those where it actually is a benefit, but as Dr Kruys was saying, it needs to be within a comprehensive assessment, if, if the cannabis is, is, is - as a cannabis prescriber is not their, their, a doctor that's involved in their ongoing care, that there is conversations and collaborative care around what is appropriate for, for that person that is accessing that medicine.

DWYER: In Joel's case, it appears that he accessed cannabis, we know he had cannabis in his system at the time of these terrible events of 13 April. In circumstances where he is seen regularly by a GP and a psychiatrist who

know of his circumstances, you can keep an eye on whether or not he's compliant. When he was well, he was not using cannabis or alcohol. Is part of the problem that when patients become unwell, they are no longer able to regulate themselves?

WITNESS WILSON: Absolutely. Absolutely. But if he had been followed up and if medicinal cannabis was an option considered, considering the risks and benefits for him as an individual, you would be looking at what, what are we hoping to achieve, what are the outcomes that we're looking for here, and let's trial it and see if it does help. If there's side effects or it's not helping, then we stop it. So it's, it's controlled and it's supported, you know, and, and Joel wanted good outcomes, you know, and so having that support to ensure that the, the cannabis use was actually of benefit rather than a risk would, you know, it's absolutely where we want to go.

DWYER: Are there any other big ticket items that you wanted to talk about in terms of recommendations before I sit down? Dr Kruys?

WITNESS KRUYS: Yeah, I just wanted to mention the, MyMedicare initiative at the voluntary patient registration which is clinically being rolled out by the Commonwealth Government, and that is about voluntary patients who want to, linking them with one general practice, so that certain MBS item numbers, such as care plans, can only be done in that particular practice.

Patients can still change if they want to, but it is recorded on the My Health Record and everybody knows who the, who their usual GP is. And, and I think it would be worthwhile if that is further developed on a voluntary basis and, and, and that there are sufficient benefits to patients and to practices to register and to work together and provide a medical home for patients with a chronic mental health illness, to prevent - you can never prevent it 100% but to reduce the risk of shopping around and, and going into different GP practices and reducing the fragmentation of care a little bit.

DWYER: Sorry.

WITNESS KRUYS: Yeah, and at the moment I'm not quite sure whether we are preparing the MyMedicare model really well for mental health patients, so that could be a recommendation consideration.

DWYER: I see. Dr Wilson, you're nodding when your colleague talks about that?

WITNESS WILSON: Yes, and, and certainly what we, what we - we have a group of quite vulnerable people who have multiple morbidities, be it mental health, physical health, potentially drug and alcohol issues, who increase in - who, who, who have, who, who have complexities and that you need a multidisciplinary team, and a GP is part of that, pharmacy, the practice nurse, mental health services. You know, that the different services are able to, to work collaboratively together, and, and MyMedicare has the potential to do this, we haven't yet seen what it could look like.

But the other thing to acknowledge is that, unfortunately, and this is something that I've seen in my research with GPs, is that increasingly, financially, it's very hard for GPs to make ends meet in a business and managing people with chronic, complex co-morbidities, because of the way they are funded. And, and they say things to me, and I, I, it totally resonates with me as well. I love doing this work. This is what we're good at. We're good at holistic care. We're really good at chronic disease. We understand the social environment that our patients live in.

And yet we're not funded to do it and you'd, you'd wear out trying to do it because the supports and the structures are so poor, and the funding is so poor, that it is, it makes it really difficult to do. And what we're seeing is, and certainly my research, GPs are cutting down their hours in general practice and moving into, you know, specialist positions, as, as we have, you know. It's a tragedy and I'd really love us to be thinking about this differently, and to be thinking about how we can work better in teams.

And, look, it's a wicked problem, if it was easier to be solved. But the different funding, and State and Federal, it is complex. But it, it's, it's really important that we're able to do this, and, as Dr Kruys said, we can't 100% prevent everything. But it's, it's the potential to actually support people to maintain their health and be actively engaged in their health, and, at the same time, maintain their autonomy and have the lives that they want is, is, you know, that's the outcome that we want, and we need collaborative care to do that.

There was one other thought that we had, which absolutely, Dr Kruys raised it in our meeting beforehand, is we're good at talking about suicidal ideation. I'm not sure that we're so good at flagging homicidal ideation.

DWYER: How might that be addressed?

WITNESS WILSON: I think it's about education around how you have those conversations about suicidal ideation, you know. So we've done a lot of work and that's been in the last 25 years. With GPs, lots of training around how do we ask, "Are you feeling suicidal? Are you thinking that you might hurt yourself?" But how much do we ask? "Are you feeling like you might hurt someone else?" And I don't think there's been - and, look, it's rare, you know. It's, and, and the tragedy on April 13, it's just, you know, it's heartbreaking and it is rare. But it's important that we know how to ask it, and how to respond, and what, what supports do we put in place.

DWYER: Dr Boros-Lavack's clinic received information from Joel's mother on 14 February that he was showing increased signs of aggression. So, around that time, is that a good time to start exploring what is going on, in someone like Joel's mind, around the aggression?

WITNESS WILSON: Yeah, absolutely. I mean, the aggression is distress, and, but, and, and it's harmful to, you know, the person, and it's harmful to others, absolutely. It's, it's a flag that says this person is unwell and needs

more support.

DWYER: If you understand that the beginning of someone's psychosis in 2000 and 2001, the psychosis included threats to kill, and threats to harm and acts of aggression, then there might be some questions that would be prompted to be asked around that time about what's going - I'm thinking whether or not you could get some questionnaires that don't just launch into, "Are you thinking of hurting somebody else", but have a series of more subtle questions to try and tease out what is going on for somebody?

WITNESS WILSON: Yeah.

DWYER: Dr Kruys?

WITNESS KRUYS: Yeah, yeah, I think there's, there's different ways to can ask the question, and it's important to do it in different ways because people may not give you a straightforward answer.

DWYER: Are you suggesting though that GPs need some more guidelines and training around what sort of questions they ask in those circumstances--

WITNESS KRUYS: Yes.

DWYER: When dealing with mental health patients?

WITNESS KRUYS: Yes, yes, I am.

WITNESS WILSON: I'm thinking of when I'm setting up confidentiality, when I'm talking to people, I will say, "What we talk together, in this room, is confidential. I will be making notes. But the times when I will have to breach that confidentiality is if I'm concerned that you're at risk of harm to yourself, somebody is putting you at risk of harm, or you're putting others are risk of harm."

So, it's - it kind of sets it up, and, and if I become concerned about any of those, I will talk to you about it and we'll create safety for you, you know. So, it's, it's setting it up in advance, and it's, yeah, so I just think it's, it is an important thing, and I, I note some of my GP colleagues are very good at doing this and others are, are hesitant. And so having some additional, you know, prompts around how to have those conversations and practice around that conversation, some training, would, would be really beneficial, and I, I would suggest also for mental health colleagues.

WITNESS KRUYS: Yes, yeah, that's the last comment I wanted to make and I refer to that in my report, is a Queensland Health report about this. So, it's not just GPs; it is health professionals in general. We don't often ask about homicidal intention and that's probably because it's so rare that it actually happens that, after a while, you stop asking. But it wouldn't hurt to make sure that that is part of suicidal training, because we do get suicidal prevention training; include asking in different ways about homicidal intention as well.

DWYER: Thank you very much. Those are my questions.

HER HONOUR: There may be some other questions.

FERNANDEZ: I'm sorry to interrupt, but just for the benefit of the families, we've been sitting for two and a quarter hours. Could we just have a very short break, please?

HER HONOUR: Certainly. If you don't mind, we'll just have a five minute break.

SHORT ADJOURNMENT

HARRIS-ROXAS: I have about half a dozen questions to ask. My name is Tanya Harris-Roxas and I act for the families of Jade Young, Ashlee Good and Dawn Singleton. I have a few questions but just firstly to put it into context, because I appreciate we're jumping around in time, the last three letters that went to Dr Grundy from Mi-Mind, there was one letter on 12 June and if that could just be quickly brought up, it's at page 44 in bundle 788A, just to refresh your memory just so we're all on the same page.

That letter reports that he's become totally well since coming off clozapine and then they're stopping the Abilify, and then the next letter is at page 45 which is from Dr Alempijevic and that also reports that she was pleasantly surprised with his progress and also that the only problem reported is he's not sleeping very well lately and then the last letter is on page 48 and that's a letter dated 19 March and that's the discharge letter that you've also been taken to.

Now if we can go to tab 793, page 24 and down to the consultation on 21 November. Now this was the consultation with Nurse Brooks and then we can see here that there's a phone call to the home landline, Joel has a script for Abilify, and then if we just go down a tiny bit we have now under plan, "Joel will self-monitor symptoms and self-determine if he will restart medication," and then if we can go down just a tiny bit again to page 25, there's a note by Dr Boros-Lavack that there's been a prescription for Abilify. Now after that consultation, do you agree that Dr Boros-Lavack should've sent a reporting letter to Dr Grundy reporting those matters that I've taken you to?

WITNESS WILSON: Yes.

WITNESS KRUYS: I agree.

HARRIS-ROXAS: That's because, isn't it, that this plan where Joel will self-monitor symptoms and self-determine if he will restart medication is an important change from what we've seen in the letter of 12 June 2019, you'd agree with that?

WITNESS WILSON: Yes.

HARRIS-ROXAS: And it's also a change from what we saw reported in the letter in September 2019 as well, isn't it?

WITNESS KRUYS: Yes.

WITNESS WILSON: Yes and I would say that any time there's a change in treatment or a development or you know, something has changed, that you need to actually let other people involved in care know.

HARRIS-ROXAS: Also this consultation came on the back of mum reporting concerning symptoms to Mi-Mind that she had observed in Joel just the day before, isn't it, and that's also why it's important that Dr Boros-Lavack should have written a note to Dr Grundy?

WITNESS WILSON: Yes.

HARRIS-ROXAS: Thank you. Now if we can go down to page - the consult on the 28th which is just one page 24 and it's just a short consultation. Thank you. Now this is a consultation where Joel was seen by Dr Boros-Lavack and my Nurse Brooks and you can see there, "Seen with Brooksy." Now it's also got here that Joel was told to start - restart Abilify for relapse prevention based on early warning signs of relapse but that he presented well today.

LYNCH: I think it reads - I object. The quote is, "Mum was contacted by telephone who told Joel to restart Abilify." It's not a direction from the practice.

HER HONOUR: Yes.

HARRIS-ROXAS: Happy to be corrected on that. Under "Plan" it says, "Start Rexulti." Now Rexulti is an antipsychotic, isn't it?

WITNESS WILSON: Mm-hmm.

HARRIS-ROXAS: And it also says here that a two week trial pack was provided.

WITNESS WILSON: Mm-hmm.

HARRIS-ROXAS: Do you agree that those are matters - that's a matter that should have triggered a reporting letter from Dr Boros-Lavack to Dr Grundy?

LYNCH: My friend omits the reference to, "Happy to start Rexulti if not going well mentally." That's the condition that's qualified.

HARRIS-ROXAS: No my question is your Honour whether or not a reporting letter should've been sent about this consult and whether or not a reporting letter should've been sent about this consult to Dr Grundy, whatever that might state.

WITNESS KRUYS: Yes it is a change in the management and as Dr Wilson

said, a change in the management or a clinical condition can be a reason to provide information to the GP.

HARRIS-ROXAS: From that clinical note, what would you expect that reporting letter to say as a GP?

WITNESS WILSON: Based on what's in this notes here, this history here?

HARRIS-ROXAS: Yes, that note of 28 November.

WITNESS WILSON: Well basically what, what they've - what they found and what the plan is and what I might be expected to see or do as a GP, and certainly one of the things that happens with giving a trial pack is people will turn up and go, "The specialist gave me this trial pack, can you give me more?" and that's the first you hear of it. You know if I'm going to be involved in the care, as is common with trial packs, you need to know the background to it.

HARRIS-ROXAS: Thank you. Can I take you to page 20 of tab 793 and in particular the consultation note on 17 February? This is a consult with Dr Boros-Lavack on that day and Joel was seen on Skype and it came on the back of what is just underneath, and if you can just scroll up a little bit, where Joel's mum had rung Mi-Mind on 14 February with concerns, and you've been taken to that note already today. Now going back up to the consult on 17 February, would you expect Dr Boros-Lavack to have written a letter to Dr Grundy reporting about that consult?

WITNESS WILSON: I think the issue here is that he's back at home, it just looks like things - and certainly on the basis of mum's concerns three days before, and that there's changes happening and his frustration, his distress, I - you know, it does raise concerns that he is - he's not doing well.

WITNESS KRUYS: But it is a little bit debatable whether this is a significant change or not--

WITNESS WILSON: Yeah.

WITNESS KRUYS: --I would say.

HARRIS-ROXAS: Can I take you to tab 790 at page 18 at paragraph 119? That's a statement by Dr Boros-Lavack, that's one of her statements, and this particular paragraph when it comes up - no, it can't be located. Just to assist, that paragraph, the last sentence of that paragraph says in this consult of 17 February 2020 that Dr Boros-Lavack agreed to continue monthly monitoring and support. So you can see that, the last sentence, she agreed to continue monthly monitoring and support.

Now if we were to go back to page 24 of tab 793 and just at the top of page 25, now it says, "Weekly appointments schedule and agreed to continue." So in November we've got weekly appointments and then it's changed on

17 February to monthly. Does that affect your answer as to whether or not there should've been a letter to Dr Grundy?

WITNESS WILSON: Certainly a change - it's certainly a change in treatment. You know and I would expect if you're moving from weekly follow up to monthly that that means that things are going well, and that it would be you know things are better and I'm - you know don't - there's not as much need to see Joel as regularly, so we've moved back to monthly.

HARRIS-ROXAS: Going to page 48 of tab 788A which is the discharge letter, now we looked at the letter dated 12 June and you've looked at the letter dated 20 September and this is the discharge letter. There are matters - this letter does not contain any information about medication or that scripts were given. Should it have?

WITNESS WILSON: Yes.

WITNESS KRUYS: Yes as we outlined before this is a discharge letter but it's not a clinical handover letter. It does not contain essential information that is required to safety continue the care.

HARRIS-ROXAS: Thank you, those are my questions.

FERNANDEZ: No questions thank you.

SPEAKER: No questions.

SPEAKER: No questions.

ROBB: I have no questions, thank you.

WILSON: No questions.

LYNCH: No questions.

MATHUR: No questions.

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

SPEAKER: No questions.

SPEAKER: No questions.

SPEAKER: No questions.

JORDAN: No questions.

HER HONOUR: Thank you. Anything arising?

DWYER: No thank you.

HER HONOUR: Thanks very much Dr Kruys and Dr Wilson. We're most appreciative of the time you've been here and for your reports as well. Thank you.

<THE WITNESS WITHDREW

DWYER: We resume on Monday for the final week of our hearing. The witnesses on Monday are Senior Sergeant William Watt, Mr Steve Iloski and Mr Manzoor, the latter two witnesses being from the Glad Group - Glad and Falcon - and Senior Sergeant William Watt is obviously a police officer. Senior Sergeant Watt will give evidence on a number of topics but in particular the Ten Second Triage rule that we talked about today, the triage plan that we talked about today.

On Tuesday there's Assistant Commissioner Peter McKenna and Deputy Commissioner Wayne McKenna. That is the executive witnesses from the police and the ambulance. On Wednesday we have Acting Deputy Commissioner Mark Kelly from the Queensland Police, Superintendent Kirsty Hales who's from the Mental Health Unit in New South Wales Police, and Brendan Flynn from New South Wales Ambulance, and those Wednesday witnesses are particularly directed to the co-responder model and any changes to the model. On Thursday and Friday, those days are set aside for family statements.

I'm reminded today that we need to try and fix on a date for oral submissions sometime later in the year, so I'll discuss that with my colleagues and families so that we can fix on a date for Monday, but we can start at 10am on Monday. If it please the Court.

HER HONOUR: Thank you Dr Dwyer and thanks everyone.

AUDIO VISUAL LINK CONCLUDED AT 4.57PM

ADJOURNED PART HEARD TO MONDAY 26 MAY 2025