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IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

5 TUESDAY 25 NOVEMBER 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

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PART HEARD

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AUDIO VISUAL LINK COMMENCED AT 9.26AM

HER HONOUR: Good morning. Today we will be hearing oral submissions, and I'll just take appearances first.

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DWYER: May it please the Court, your Honour, Dwyer for the record. I appear as your Honour's counsel assisting with Ms Sullivan and Mr Murphy of counsel, instructed by the Crown Solicitor's Office, and Ms Amber Doyle is our senior solicitor here in court, accompanied by a number of other solicitors.

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HER HONOUR: Thank you, Dr Dwyer.

HARRIS-ROXAS: May it please the Court, my name is Harris-Roxas, initial T. I appear for the families of Ashlee Good, Jade Young and Dawn Singleton, led by Ms Sue Chrysanthou, who is logged in today.

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HER HONOUR: Thank you. And welcome to the family members who are here in court.

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FRECKELTON: May it please, your Honour, my name is Freckleton, initial I, and I appear with Ms Melis, initial C, instructed by Caroline Harrison. We appear for the Queensland Police Service.

HER HONOUR: Thank you, Mr Freckleton.

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JORDAN: May it please the Court, my name is Jordan. I appear with Ms Bonnor for Scentre Shopping Centre Management Pty Limited.

HER HONOUR: Thank you, Mr Jordan.

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CASSELDEN: May it please, your Honour, my name is Casselden. I appear on behalf of Glad Group Pty Limited, instructed by McCabes Lawyers.

HER HONOUR: Thank you, Mr Casselden.

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WILSON: May it please the Court, my name is Wilson. I appear for Dr Pietsch, instructed by Meridian Lawyers.

5 HER HONOUR: Thank you, Mr Wilson.

GNECH: Thank you, your Honour. If the Court pleases, my name is Gnech, initials are C R, solicitor with Gnech & Associates, on behalf of five individual Queensland Police officers.

10 HER HONOUR: Thank you, Mr Gnech.

MATHUR: Good morning, your Honour. For the record, Mathur. I continue to appear for Drs Grundy, Ruge, Parker and Barkla.

15 HER HONOUR: Thank you, Ms Mathur.

CALLAN: Your Honour, Callan. I appear with Ms Richards, instructed by Ms Atherton of the Office of General Counsel on behalf of the Commissioner of NSW Police Force.

20 HER HONOUR: Thank you, Ms Callan.

CHIU: May it please the Court, Chiu appearing for NSW Ambulance and NSW Health, instructed by Makinson d'Apice.

25 HER HONOUR: Thank you, Mr Chiu.

LYNCH: If your Honour pleases, Lynch is my name. I appear for Dr Boros-Lavack.

30 HER HONOUR: Thank you, Mr Lynch.

WALZ: May it please the Court, your Honour, my name is Walz. I seek leave to appear on a limited basis for Standards Australia.

35 HER HONOUR: Thank you, Ms Walz. Yes, and on the screen we have Ms Robb? We can see you, we can't hear you, but I'll take your appearance, Ms Robb, thank you. We'll learn sign language. Dr Dwyer.

40 DWYER: Your Honour, I just wanted to note that there are some family members online.

HER HONOUR: Yes.

45 DWYER: I don't need to note them, but we appreciate their presence during the court throughout the course of the hearing and note that they are still very engaged in this process.

50 HER HONOUR: Yes, absolutely.

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5 DWYER: Your Honour on behalf of the counsel assisting team, and no doubt all my colleagues at the bar table I just wanted to start this process of oral submissions by acknowledging the families, and also that it has been some months since we have seen them after an intense five week period where we saw them most days and got to know some family members over that period of time and feel for them deeply. The families of Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Pikria Darchia and Faraz Tahir have assisted in this process greatly throughout.

10 Your Honour has already recognised that the inquest process is very demanding for families. It doesn't end with the hearing of evidence, and families have participated in the process of exchanging written submissions with a patience and commitment that they demonstrated throughout the process. The written submissions of families have been very carefully
15 prepared and will provide valuable assistance to your Honour in the preparation of your findings.

20 Each of the families who suffered the loss of a loved one have acknowledged that an inquest was not just required by law, but a valuable process to learn whatever lessons can be learnt to save lives. But nevertheless in the course of written submissions your Honour is reminded that the process is challenging, and the recommendations proposed are commended to your Honour; families hope they will be embraced by those to whom they are directed so that there is a meaningful outcome from the inquest.

25 Over the months since your Honour adjourned the proceedings an enormous amount of work has been done so that the Court is in the best position possible to produce findings before Christmas, as your Honour hopes to do. I understand that the Court is still on track thanks to the efforts of all those
30 participating.

35 Parties have exchanged written submissions; it's not an easy task to distil the 54 volumes of evidence tendered and the five weeks of transcript, but that has been done. That reminds me your Honour that there is some additional material for tender; I have a volume here, one for your Honour and one tender copy. That is all to go within the brief of evidence, so they are individually tabbed. Perhaps I might hand that up now.

40 HER HONOUR: Yes, thank you.

DWYER: That's all been circulated and there's no objection to that material.

HER HONOUR: Thank you Dr Dwyer.

45 DWYER: Just to explain the process then for everybody listening, the Court will recall that an issues list was distributed before the hearing that was developed in consultation with parties - sorry your Honour that forms part of exhibit 1.

50 HER HONOUR: Thank you.

5 DWYER: An issues list was distributed before the hearing. It's the task of counsel assisting to address each of the issues in submissions, and that helps to explain why the submissions of counsel assisting alone are some 670 pages for your Honour to read and somehow distil into findings. Interested parties then replied to our written submissions and that's what's been happening over the course of the last few months.

10 Families divided responsibility for targeting particular areas that they were focussed on, and that will be of assistance to your Honour. Other interested parties like Scentre Group, Glad Pty Ltd, NSW and Queensland Police, NSW Ambulance, Dr Boros-Lavack and other doctors and interested parties addressed the issues that concerned them. So their written submissions are significantly shorter, but nevertheless dense and helpful to your Honour.

15 In many circumstances, in fact in most circumstances, the submissions made by counsel assisting, particularly as to factual findings, were adopted by other interested parties. In a small but still significant number of areas, the proposed findings, or indeed recommendations, were contentious or the subject of
20 suggested variations. So they necessitate submissions in reply. That's the purpose of the two days of submissions set aside this week, today and on Friday. Having oral submissions reduces the time that would be required if there was another round of written reply submissions that needed to be circulated. It also, in our respectful submission your Honour, facilitates the
25 public understanding of these issues, because there was so much interest in what took place in the tragic events at Bondi Junction on 13 April 2024.

30 A tight timetable is required for oral submissions if we are to finish in that time. As counsel assisting, I will necessarily have the floor for much longer than others, and am on my feet for about two or three hours; we've clawed back some time from parties who did not require it. It's simply not possible to outline all of our written submissions in that time, but I propose to address your Honour on the major issues in these topics and to reply to any major areas of difference.

35 For transparency, and again to assist anybody following these proceedings, I just want to now put up the index to the counsel assisting's written submissions on the screen. They're divided into 13 parts. Hopefully everybody can see that who's following, but otherwise we can make that index
40 available. I will read those onto the record, they include Part 1, the determination of statutory findings, which are not controversial. Part 2 is Mr Cauchi's early life and mental health history. That's an important section with respect, that includes his treatment in the public health system, from 2001 to 2012, treatment by the Mi-Mind clinic staff and psychiatrist Dr Boros-Lavack,
45 from 2012 to 2020. His discharge from that service and his relatively brief interactions with doctors thereafter. And the relevance of going back in time to the public health treatment is not to scrutinise that in great detail, but to provide a very useful contrast to the treatment between timeframes in the public versus the private section, and what that ultimately means in terms of
50 recommendations.

5 Part 3 is Mr Joel Cauchi's interactions with the Queensland Police Service. Part 4 Mr Cauchi's movements in New South Wales from 2023 to 24. Part 5 the tragic events of 13 April 2024. Part 6 the security response to those events. Part 7 the response of NSW Police Force to what happened on 13 April 2024. Part 8 the response of NSW Ambulance to those events. Part 9 emergency services interoperability and what was to be learnt from the investigation of those issues. Part 10 the knife used in the attacks and ultimately the difficulty of regulating those weapons. Part 11 media reporting, including the pain that it caused to the families of victims, what can be done better to balance public interest in major events, and the need to limit trauma and safeguard the privacy of those most affected. We've been able to point in that chapter your Honour to efforts that have been taken in the United Kingdom to try and address the balancing exercise.

15 Part 12 is the mental health crisis in New South Wales and Queensland, and the way that focussing on what happened to Joel Cauchi and his decline, suggests the need for a rethink in the care of persons who suffer from severe forms of chronic schizophrenia to make sure that they don't slip through the gaps and become unwell. That was the subject of evidence from the panel of eminent experts that your Honour heard from, and has been the subject of significant enquiry and some important proposed recommendations. Part 13 then is the summary of the proposed recommendations.

25 We commend to your Honour the 26 recommendations put forward that have been drafted and then re-drafted after receiving submissions from parties, and have been the subject of very careful deliberation and consultation with the expert psychiatric panel where that was relevant, and which counsel assisting says to your Honour would make a meaningful difference to avoiding another tragedy like the 13 April 2024, and to saving the lives of people in the event that there was, god-forbid, another attack of this nature.

35 In some circumstances your Honour may find that parties have already implemented the proposals that counsel assisting have put forward, so that your Honour may think that after hearing from them that a formal recommendation is no longer necessary. It is a less understood part of the role of coronials and what can be achieved in them, that interested parties often respond by implementing reform either during an inquest, or in the lead-up to an inquest, or on the receipt of draft recommendations. Where that happens they are to be commended; that has happened in some circumstances in this case, and it might mean that your Honour doesn't have to make those recommendations, but it is part of what makes the coronial process so important in our jurisdiction and in others.

45 Might I just reiterate before I get started again that the focus has been very much not on blaming individuals who were dealing with exceptionally difficult circumstances often, but on systems and on saving lives. Nevertheless a review of the circumstances of this tragedy did require individuals to reflect on their own actions, to think about what they could have done differently if possible, to think about systems change or training that would assist them,

and that process is not without challenge. It sometimes causes tension.

5 We've been able to move through that and work through that tension in a constructive way during this inquest, and in most cases individuals and organisations have demonstrated reflection and cooperation that has been of great assistance to your Honour, and that has enabled the Court to get to the point we are now.

10 There is no need for me in oral submissions, or I imagine any of the parties, to cover the distressing details of 13 April, which are well known and are not in dispute. We know that on that day Joel Cauchi, who was suffering from an acute episode of psychosis, on the background of chronic treatment resistant schizophrenia, perpetrated an attack on 16 victims. Six of them suffered fatal wounds and were killed. Five of those six were women. The one male killed
15 by Mr Cauchi was Mr Tahir, the young security guard on his first ever shift at Westfield Bondi Junction. Ten other people were wounded on that day and of those ten, two were men, and they were both very seriously injured.

20 About five and a half minutes after he began the attacks Joel Cauchi was fatally shot by Inspector Amy Scott, whose professionalism and courage and humility is now well known and beyond doubt, and I don't have to go over those details again.

25 That leaves me your Honour five main topic areas to address in oral submissions, that are these; firstly I'm going to start with the need for very significant reform of the mental health sector, away from crisis response care, to public care for chronic conditions. That was the subject of unanimous expert opinion.

30 Secondly I'll focus on the mental health of Joel Cauchi, how he came to be unmedicated and unsupervised by April 2024, and whether there were missed opportunities to ensure that he stuck with treatment, in particular that involves a focus on the treatment of him by Dr Andrea Boros-Lavack. Third I'll cover
35 the response of Scentre and Glad staff on 13 April. Fourth the response of NSW Police and Ambulance, and fifth the media. I'll touch on Queensland Police during that period, but not in any - their actions and response are uncontroversial.

40 In relation to each of those five areas I'll take your Honour to relevant recommendations. So might I then commence with the first of those issues about which there is I anticipate very little controversy, and that is the need for significant reform of the mental health sector. In both Queensland, where Mr Cauchi lived for most of his life, and in New South Wales, where his life
45 ended and where he caused so much harm to others, there is a serious lack of adequate community based treatment focussed on chronic care needs, and a shortage of housing services for persons who are mentally ill, that's both long term and short term housing.

50 Addressing that deficit is not a quick or easy fix, because it comes on the back of decades of under-investment in those areas. So it's not a political statement

5 to say that we need significant investment in those areas to keep the community safe. It is absolutely critical for keeping people who live with schizophrenia safe, and minimising the risk to others; that is the risk of harm that may be caused by individuals who commit acts of violence when they are off treatment and unwell.

10 The point has been made previously throughout this hearing that it's important not to inadvertently demonise individuals suffering from schizophrenia, the vast majority of whom are never violent, but it is a reality that a very small number of homicides are committed by persons like Joel Cauchi when they are suffering an acute phase of the illness and experiencing psychosis that leads them to do terrible acts that they would never commit if they were well. Dr Olav Nielssen a forensic psychiatrist who was one of the five experts on that panel who gave evidence in Court is truly a specialist in this area, as are his colleagues. He explained this. He said:

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

20 In Denmark, a homicide in those circumstances is committed on average once a year. But it is no comfort to the families of victims that these incidents are rare.

25 Dr Nielssen recalled three high profile cases that he was involved in where a patient who had come off the antipsychotic medication clozapine had gone on to kill one or more people. In the submissions of counsel assisting, we set out in detail some of the reasons why the current system has become unsuitable after many decades of deinstitutionalisation and underinvestment. Your Honour heard that deinstitutionalisation started in this country in the 1960s. That's how long that process has been evolving.

30 On the basis of the expert evidence the Court heard, we have proposed recommendations aimed at practical changes in the system of healthcare that would dramatically improve the lives of individuals living with treatment resistant schizophrenia and their families and the communities. If implemented, those changes would mean that people like Joel suffering from a chronic condition with a high risk of relapse into psychosis if unmedicated will be less likely to fall through the cracks. It's impossible to understand those issues without an historical lens that I've alluded to. As counsel assisting has set out in our submissions, arguably the most significant policy shift in the provision of mental health services in this country has been the process of deinstitutionalisation that commenced in the 1960s.

35 That term refers to a shift in mental health policy and service provision away from the asylum era to less custodial and segregated approaches in which

services are delivered in community settings. The consequences of that policy are still felt today. Part 12 of counsel assisting's submissions set out the history of that shift and related reports on the impact and what should be done. The Richmond report in 1983, the Burdekin report in 1993, the Productivity Commission report in 2018. Those reports will be supplemented by your Honour's findings. This is a continuum of an investigation into that issue. Nobody is suggesting we go back to the asylum era.

The aims of deinstitutionalisation are noble, because many of the places that used to be referred to as "asylums", itself an offensive word to us today, would not be acceptable in a society that values the human rights of patients. Deinstitutionalisation fits with the current philosophy of the least restrictive care. Indeed, the Mental Health Act in New South Wales and Queensland and similar jurisdictions requires that mental health care is provided in the least restrictive environment consistent with safe and effective care. For instance, a person should not be scheduled and detained in hospital if they can receive appropriate care at home with support. The problem is that there are not sufficient health care and accommodation services in the community to address the needs of those living outside the acute hospital system.

Dr Nielssen explained that there are a number of reasons why maintaining good care for chronic sufferers is now so difficult, including population growth and a failure to keep up with community needs. Dr Nielssen started his career as a psychiatric nurse, so he's very well placed to give the Court a longitudinal view of life on the ground for nurses and doctors caring for patients. He explained this in evidence day 16, 22 May this year on p 1461. He says:

"When I started training in the mid-late-80s, the community health centres were a pretty functional type of system. So you could ring each centre directly. You didn't go through an 1800 number. I mean, I have the most dispiriting experiences of trying to refer people through that number these days. Their case managers knew their patients pretty well back in those days. There were psychiatrists at each of these community health centres. So in other words the psychiatrists knew the patients who were there."

Since then, he says it's become much more chaotic. The reasons that it has happened are multiple, he tells the Court. He said:

"Professor Large has alluded to just a growth in population really. The sort of services haven't really kept up with that. But they include the change to the Mental Health Act so that we don't respond to deterioration or anticipate deterioration. We wait now until people have deteriorated."

He's saying effectively crisis driven until after people have deteriorated and then they're scheduled. Dr Nielssen said:

"Added to this is the absence of short-term crisis shelter for homeless people with a dual diagnosis of mental health and homelessness. Also, there's been a change in the patterns of illegal drug use, particularly

methamphetamine, but also potent cannabis".

5 I interrupt myself to say we know that cannabis was a problem for Joel Cauchi and Dr Large commented on the likely contribution of that to his decline. As I'll
10 come to shortly, all of those issues have placed a strain on the acute mental health services. But also, and we're hearing more about this in the inquest context, a massive strain on our police forces. Our police forces around the country have faced massive increases in callouts, and they are now expected to manage complex mental health cases, when that was never intended to be their core business. It's a further strain on their resources. It's a further strain on their morale. The figures that I'll come to in New South Wales and Queensland are staggering.

15 The expert panel was made up of some of the most well respected psychiatrists in the country. Dr Olav Nielssen, Professor Matthew Large, both of those doctors from New South Wales who have given evidence on numerous occasions in this Court and other courts around New South Wales and the country. Professor Edward Heffernan from Queensland, Professor Anthony Harris from Victoria, both of whom are renowned experts in their field,
20 and the international perspective was given by Professor Merete Nordentoft of Denmark who is herself someone who is recognised internationally. The panel agreed on the need for greater emphasis on integrated care for patients with chronic conditions. Again, to quote the report from Professor Nielssen but only really because he sums up so succinctly what the others agreed with. He says
25 at para 147:

30 "Australia has a region based community mental health system that generally responds well to mental health crises, in particular people who have attempted or threatened suicide. However, there's a significant gap in the availability of services for people with chronic and severe forms of mental illness who require long-term treatment. In order to ration the available caseworkers and doctors, the community mental health system in New South Wales has adopted a model of episodes of care in which patients with chronic conditions who are deemed to have stabilised are
35 discharged to the care of general practitioners or to psychiatrists in private practice."

40 I pause to note that is exactly what happened here in Joel Cauchi's case. Dr Nielssen says, "In my opinion this policy is utterly self-defeating because of the inevitable relapse and re-presentation of many chronic patients sometimes alarmingly unwell." He goes on to say that:

45 "Improvements in services available to persons suffering from severe and chronic forms of mental illness could include an improvement in the productivity of community health centres for example by the switch from a model of episodes of care to one of lifetime care for people with chronic and relapsing forms of schizophrenia and bipolar disorder who have required regular admissions to hospital".

50 That has led counsel assisting to suggest significant reform in this area.

I should say that hasn't come from the thought bubble of counsel assisting. This has been drafted by those experts who, over the course of the months since they gave evidence have communicated with each other and exchanged drafts of the written submissions to craft what they think is a framework that would work, and counsel assisting has then adopted those ideas into something that we think your Honour could shape as a recommendation. Could I just have that on the screen? It's draft recommendation 2.A. It's directed to the NSW Health Department. It will be too difficult to read there, I imagine your Honour, but we can make that available to the parties. It may be that there's an application to see the draft recommendations.

In short, it's suggested that NSW Health Department should assume the role of the lead agency in advising the government on the decline of and resultant demand for mental health outreach services in New South Wales, and consider developing an outreach psychiatric service that can collaborate with stakeholders to evaluate and engage people with severe untreated mental illness. The remainder of the recommendations talk about the development of guidelines for deprescribing antipsychotic medication and the development of a chronic care model, rather than acute episodes. That can come down. I think it's a bit too hard to follow on the screen, but we'll make that available.

I should say that given the scale of that recommendation, it's understandable that NSW Health seeks a bit more time for their lead psychiatrist to comment on it. The Chief Psychiatrist in New South Wales is Dr Murray Wright. Dr Wright has asked to be able to respond to that by 5 December. I should say Dr Wright is also very well-known and renowned in this country, and we will value the contributions that he makes. We're grateful particularly to Mr Chiu of senior counsel for the assistance in responding to that. We appreciate that this is a significant reform, and that a significant impost has been put on parties to be able to assist your Honour in a relatively short period of time. But it's imperative that this results in action rather than just another report.

Another topic about which there was furious agreement was in relation to the need to provide more short and long-term housing for individuals experiencing chronic mental health conditions like schizophrenia, not just for the sake of those persons who are unwell, but for the sake of everybody in the community in terms of providing a safe and healthy community. There was compelling evidence from Dr Heffernan, Dr Nielssen, Dr Large and Dr Harris about the link between the lack of housing and the deteriorating mental health of patients.

Shortly after the events at Bondi Junction, Dr Olav Nielssen and Professor Matthew Large published an article together entitled "Schizophrenia and homelessness can be a deadly combination". In it, they note that the stress of homelessness can cause or contribute to schizophrenia, and it also makes it almost impossible to get treatment. But they also offer this hopeful analysis. I'm quoting from their article:

"Housing people experiencing homelessness while mentally ill is a finite problem. It has been estimated that there are as few as 3,000 people

5 with chronic mental illness living in the open in Australia, many of whom revolve between hospitals and prisons at vast expense to the community, but with very high mortality and poor health outcomes. Building and managing small scale communities for the homeless who are mentally ill will not only save money, it will also reduce stress on public mental health systems and improve their outcomes. It will also reduce the likelihood of further tragic events similar to those in Bondi Junction on Saturday."

10 They were writing that article immediately after the events. I pause to note that it's not a stretch to say that if those persons could be accommodated so they're not a constant revolving door in and out of hospital, then it helps to alleviate the strain on police that we have heard and free up their resources for the other important work they do in the community. Dr Niessen opined:

15 "A major gap in the mental health services available in New South Wales is supported accommodation for people with severe forms of mental illness, mainly schizophrenia, who require basic support and supervision of adherence to medication to remain well. A significant proportion of hospital inpatients occupy those places, because there's no suitable
20 accommodation where people with severe mental illness can receive medication supervision. Another area in which the availability of services has declined is in the shelter accommodation and medical care available to homeless mentally ill".

25 I'll pause your Honour, because these figures really tell a story.

30 "In 1991 there were about 1,150 short stay beds in the four main inner-city hostels in Sydney where people who were homeless could also obtain meals, receive medical and psychiatric care and access a range of welfare services."

35 1,150. "Now there are less than 300 temporary beds and walk-up psychiatric care is only readily available at Matthew Talbot Hostel in Woolloomooloo and the Mission Australia Centre in Surry Hills."

So, despite the massive increase in population, we've had a very significant decrease in the availability of those short-term beds. And as Dr Niessen and Professor Large say, that is a finite problem. That is fixable.

40 In other hopeful evidence, the Court heard from both Dr Niessen and Professor Harris about the successful models of care that they have personally driven in Habilis in New South Wales and Haven in Victoria. Might I ask those assisting your Honour to put up just a screenshot from Habilis.

45 Dr Niessen has been able to achieve this accommodation in a very - well, in a number of years, by fundraising personally and by asking NSW government for assistance and support. I understand he's received that, and so he's been able to create, with the help of others, accommodation that involves 21 self
50 contained units with a nurse - sorry, I'm trying to read that myself - it's 21 self-contained units with a secure, calm and supportive environment and that

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involves mental health professionals assisting.

5 That's obviously a snapshot of what is required, but it is encouraging and it's a glimpse into what could be achieved for the community with the further injection of resources, which will ultimately, he makes the point, save a lot of money in the long term.

10 There are similar supported accommodation in Victoria, which is called Haven, and we put those websites up so that people can go to them if there's an interest in them. If the media is interested in reporting on these important reforms, they can do so. There's plenty of information available about how they are transforming the lives for the small number of people they've been able to help.

15 Your Honour, that issue has led us to recommendations 21 and 22 which are directed to the Minister for Housing, the Minister for Homelessness, and the Minister for Mental Health to address those issues for short term and longer term accommodation.

20 Finally then on this issue, a topic was raised in relation to outreach services. Dr Niessen gave evidence about the decline of outreach services, which directly correlates to the number of people who are sleeping rough. Again he draws on his training back in the 1990s, and he says:

25 "When I was training at St Vincents, one of our services provided outreach to the four big hostels. Matthew Talbot was the biggest, which had 450 residents. Now it's got 66 residents. So the decline from about 1,100 to less than 300 beds exactly coincides with the number of people who sleep in the open in Sydney every night, in inner city Sydney every night."
30

He says that's probably more than a coincidence.

35 We've set this out in some detail in our written submissions, so it is all there for policy makers to understand the true issues and to take action, your Honour.

40 Professor Nordentoft explained that in Denmark they have a psychiatric emergency outreach facility where psychiatrists can be called by the police or by staff members in support of housing facilities. Also, families can call on that outreach service. That's perhaps beyond the imagination of our services at this stage, but it does suggest that getting mental health professionals into the community attending to outreach and linking patients to longer term care should form part of our system.

45 That's what's led to a recommendation to the Minister for Housing, Homelessness and Mental Health that the NSW Government convene a committee of experts to advise on the decline of and related demand for outreach services and to follow the advice in relation to providing, or setting up, those outreach teams.
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Your Honour, can I move onto part two then of our oral submissions, which relate to the mental health care from psychiatrists and GPs of Mr Cauchi. I've already referred to the panel of expert psychiatrists retained from around Australia joined by Professor Nordentoft. Dr Boros-Lavack retained
5 Professor Matthew Large from New South Wales, and I've already referred to his work in this area. He's also a highly respected forensic psychiatrist well known to this Court.

10 As counsel for Dr Boros-Lavack acknowledged in written submissions, it is difficult to imagine a more eminently qualified panel of Australian experts to assist the Court to assess whether or not Dr Boros-Lavack's care of Joel Cauchi met acceptable professional standards expected of an Australian psychiatrist working in private practice.

15 Your Honour, we know too well what Mr Cauchi did on 13 April, but the real question to explore in more detail was why. Why did Joel Cauchi perpetrate the attack. How did he get so unwell and were there opportunities to prevent his decline into psychosis. That necessarily involves reviewing these issues that are set out again in detail in written submissions.

20 The management of Joel in public and private mental health sectors in Queensland. The adequacy of treatment once he was transferred to the private sector in Queensland, the Mi-Mind clinic, in 2012. Given that he was well managed on a stable medication regime for many years - 2010 to 2019 -
25 why was he weaned off all antipsychotic medication? Fourthly, when did Joel start to become obviously unwell, what were the early warning signs, and were they managed appropriately by Dr Boros-Lavack? Fifth, how did Joel come to be discharged from the Mi-Mind clinic, and could or should that have been managed more effectively by Dr Boros-Lavack, or indeed his general
30 practitioner at the time, Dr Grundy? And finally, what is the evidence of his mental state between the time he was discharged from Mi-Mind in February 2020 until the time he caused the deaths in April 2024. Were there missed opportunities to intervene?

35 That necessarily involved a review of the general practitioners, two psychiatrists, and Queensland Police who interacted with him relatively briefly over that period of time. That is, they interacted with him for brief interludes during that time. Importantly, it involves a focus on what are the potential reforms that might prevent it from happening again. So, without further ado,
40 I'll commence an overview of this area and the major issues in reply.

I'll just pause. Your Honour, morning tea is currently scheduled for 11.15, but if your Honour or those listening need a break beforehand, would you interrupt me.

45 HER HONOUR: Of course.

DWYER: Just a reminder briefly, or as briefly as possible, of the key facts canvassed in written submissions. These are canvassed in great detail in
50 written submissions and I'm glossing over some of them here as quickly as

I can so that it makes sense to everybody listening.

5 Joel Cauchi was raised in Toowoomba by his parents Michelle and Andrew Cauchi. The Court is informed that Joel was a bright young person who made friends easily, but Michelle explains in her evidence that in hindsight the first signs of his illness emerged when he was about 14 years old. They became more apparent from about 17, and Mr Cauchi was exposed to cannabis around the age of 14.

10 The expert panel explained that if a person predisposed to mental illness is exposed to cannabis, that drug is very detrimental to their mental health. Professor Large was at pains to say that that is an issue that may not be as well understood in this community as it should be, because cannabis for so many people in the community is relatively harmless, but it is not for people
15 who are prone to mental illness. And for people who are prone to mental illness, they might be drawn to cannabis to try and stop what they are experiencing such as voices in their head, so it becomes a vicious cycle.

20 On 20 July 2000, Andrew Cauchi, Joel's father, attended the Toowoomba District Mental Health service after advising his own GP that he had concerns for his son. Those concerns at that time included aggression, that he was withdrawn, he was verbally abusive, and he'd made threats to kill his father. And at that time Andrew Cauchi disclosed his own mental health history.

25 Mr Cauchi junior, so Joel, was first admitted to Toowoomba for treatment of a mental health condition on 26 January 2001 when he was 17. He was brought in by police at that time, and the examination notes were the subject of investigation at the inquest. I'll just put them on the screen. These will be familiar to those who followed the evidence at the time. The screen to
30 your Honour's right looks a little fuzzy to me, but we'll battle on. They are exhibit 1, volume 17, tab 783, page 634 to 635.

35 In short, what they demonstrated are that the parents rang police after Joel smashed a screen door, claiming that he was distracted by the demons. About two weeks beforehand he claimed that he was feeling and seeing demons entering his body. He was observed to be scratching his body and making movements to pull out the demon or devil from his body, and that behaviour had become worse for the past week. He told his father that he was possessed by the devil and tormented by that and declared that "either the
40 problem will be gone within this two weeks or I will be gone" were suggestive of suicidal ideation.

45 He talked about having a spiritual problem since September 2000. He narrated that he saw frogs trying to swallow him, and that was also accompanied by a bad smell. So it was evident then that he was experiencing auditory, visual and olfactory hallucinations along with acts of aggression and suicidal ideation.

50 The relevance of putting that, or drawing your Honour's attention to that, both during the hearing and now was that it's important when early warning signs

began to emerge, as we say they did, probably by the end of 2018, but certainly by October 2019.

5 We see throughout the course of those notes that, for example, the next day after he was admitted, Joel experienced paranoia about his safety, and particularly his food and water. He refused oral medication because he didn't want to go to sleep for fear of being raped. He talked again about how the devil had entered his body.

10 On 23 February 2001, so after about a month, Joel was discharged from hospital and given the medication Olanzapine, Zyprexa at 10 milligrams at night. Obviously that drug is an antipsychotic.

15 From the time of the hospital discharge on 23 February 2001 until early 2012, Joel received care from youth mental health teams and then adult mental health teams in Queensland. In May 2002 he was transferred to the mobile intensive rehabilitation team, otherwise known as MIRT, in Queensland which provided seven days a week intensive specialist mental health case management to consumers with complex mental health issues living in
20 community. And that's the type of coordinated care for chronic mental health illnesses that Dr Nielssen says is so important to make sure exists and is sufficiently resourced.

25 Joel continued to experience positive signs of schizophrenia after his release from hospital, so doctors trialled different medication and doses, which is entirely appropriate in these circumstances. There was an increase in Olanzapine to 20 milligrams at one stage, and then it was changed to the antipsychotic risperidone. Part of the challenge, as your Honour knows, for psychiatrists and GPs in this area is that different drugs work for different
30 people in different quantities, and there is a period of exploration to try and work out what's working for a particular patient.

35 From 1 to 15 October 2002 when Joel was 19, he was admitted again for the second and final time to hospital. That was again to Toowoomba Base, and that was to manage a medication change from risperidone to clozapine upon referral from Dr Nicky Stephens, who was the community psychiatrist. The drug clozapine, otherwise known as Clopine, or a version of it known as Clopine, the management of that drug assumed significant importance for Joel and in this inquest, and is the subject of recommendations in relation to
40 guidelines that should be developed.

45 Professor Neilssen commented that it seems that Joel continued to have symptoms despite treatment with medications in the community, and the negative symptoms probably also contributed to the decision to initiate clozapine.

50 So your Honour heard about schizophrenia causing positive, negative and cognitive symptoms, and your Honour heard about the way in which Joel continued to exhibit each of those symptoms throughout the course of his illness at different times, although the positive symptoms certainly settled

down.

5 When he was admitted for the second time Joel's diagnosis was recorded as schizophrenia. The management plan was for a case manager in community to follow-up with a MIRT and clozapine clinic. The current treatment was to continue clozapine at 300 milligrams daily, as he was at that stage. Copies of the hospital's discharge plan for the admission were sent to his MIRT case manager and to Dr Richard Grundy, his general practitioner, who gave the evidence in these proceedings.

10 Upon Joel's discharge from hospital in October 2002 he was returned to the care of the MIRT as planned, and his clozapine dose was gradually increased in the community. In our submission your Honour would find that from 2002 to 2012 Joel was managed very effectively in the community by the public mental health team. He lived with his parents who were proactive in his care. His team included a psychiatrist who monitored his response to medication and a psychologist as case manager, and others involved in that team.

20 Occasionally Joel experienced positive symptoms but they were largely under control. For example he was seen by a MIRT psychologist in April 2006 and reported still sometimes hearing voices that told him to do "something bad" to himself. He experienced a brief period of positive symptoms during 2008, following a change in the brand of clozapine for all Queensland patients.

25 Michele Cauchi was concerned in 2007 that her son was deteriorating and that it might be related to the change in Clopine, and it's one of the examples where she then notices that change, she's right about that change and she's proactive in getting him care. At that time Mr Cauchi was performing rituals, and he also had a bad persecutory idea in relation to god and the devils killing him. A note in his records record at that time "Passivity phenomenon persists. Auditory hallucinations. Tactile hallucinations. Risk of deterioration", and the impression recorded in 2008 of was of relapsing schizophrenia and an exacerbation of his OCD.

35 So it's not correct to say that Joel Cauchi's symptoms ever resolved entirely in the community or at any time. His schizophrenia was sadly a chronic condition first diagnosed when he was 17, and then severely impacting him in his life throughout, which required ongoing management and review. On 3 July 2007 he started taking the antipsychotic drug aripiprazole, whose trade name is Abilify, in addition to clozapine, in order to manage his symptoms. The clozapine was continued, at this stage it was at the very high dose of 40 600 milligrams daily.

45 In Queensland in late 2011 some patients who'd been stable on clozapine, began to have their mental healthcare transferred to private clinics, which for the first time were then able to prescribe clozapine outside of the public mental health service. Your Honour heard that clozapine is a drug with side effects including impacting on the heart, and so it has to be carefully monitored.

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Joel was seen as a good candidate for the transfer of care, because at that time, having been stable for a while, he showed good insight into his illness, he had constantly adhered to his treatment, he had no significant risk factors for relapse at that time in 2011 and he had considerable family support,
5 particularly from Michele Cauchi

So it was that Joel Cauchi came to be referred to the Mi-Mind clinic to be managed by Dr Boros-Lavack, with his GP, Dr Grundy, as the referring general practitioner. At the time of his discharge into the public sector, Joel was
10 managed on a clozapine dose of 550 milligrams. The last public psychiatrist to see him, Dr Narayanan, suggested reducing that dose slowly and checking his clozapine levels; once he had reached a daily dose of 400 milligrams, to ensure that the dose was within the therapeutic range. Joel was to continue taking the aripiprazole while reducing his dose of clozapine to around that
15 range.

Dr Narayanan also discussed with family the early warning signs, especially when reducing the dose, that is the early warning signs of relapse to look out for. There was no suggestion from Dr Narayanan, or anybody else in the
20 public sector, that Joel should be unmedicated at any time in the future; the plan was to reduce the dose of clozapine, monitor him carefully and then test the levels when he was at about 400 to make sure that they were still in the therapeutic range.

The expert panel agreed that Mr Cauchi receive mental healthcare of a very high standard in the Queensland public health system, over that period of time, both as an inpatient and through the community mental health team. Professor Nordentoft notes that he was seen frequently by a psychiatrist and followed with case management from a multidisciplinary team, who saw him
30 during home visits, had meetings with his mother and had multidisciplinary team conferences about his condition. She also noted that his cognitive functioning was thoroughly assessed with an appropriate battery of gold standard tests.

From March 2012 until early 2020 Mr Cauchi was a patient of Dr Boros-Lavack, a psychiatrist at the Mi-Mind Centre at Toowoomba. Dr Boros-Lavack saw Joel on roughly a monthly basis, and saw other psychiatrists when she was unavailable. In addition to his psychiatrist Mr Cauchi saw a mental health nurse through the clozapine programme at
40 Mi-Mind, on a regular, again roughly monthly basis. Three nurses acted as his clozapine coordinator and case managers. They were Debbie Moody until August 2015, Clare Schwarz until January 2018 and Andrea Brooks until 2020.

The role of those nurses included ongoing mental state examinations that they recorded in notes, risk assessments, medication compliance, review of effectiveness and any side effects or adverse reactions, monthly Clopine clinics to monitor patients, updating the national database for Clopine, patient education, data entry and collection for their health records, and again referrals.
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5 Nurses Schwarz and Brooks gave evidence, and in our submission they would've impressed your Honour as caring and competent. Given the short period of time that I have in oral submissions, I won't address that any further, save to commend their evidence to your Honour. Mr Cauchi did not see a psychologist during his time at Mi-Mind, and that was regrettable because it would've been another set of eyes on him when we say there were early warning signs from late 2018. But it had been the intention of Dr Boros-Lavack that he see a psychologist, and Joel declined to see a psychologist. So in circumstances where he had nurses and a psychiatrist, he couldn't be forced to see a psychologist.

15 Professor Nielssen commented that the set-up at Mi-Mind was I quote "exemplary in some ways", with a key benefit being that there was the one doctor all the time, with appropriate supports and coverage, "where you'd assume the person would sort of follow the doctor's advice, you know from building up a trusted relationship." The panel agreed that he received very good care for the seven or eight years while he was at Mi-Mind.

20 I pause to note that it wasn't just in the private sector that Joel was able to achieve consistency with a psychiatrist, because we see in the notes that he had a consistent psychiatrist and psychologist for long periods of time, in the public sector as well, and was able to build up a trusted relationship, including with Dr Nicky Stephens, who came back on the scene to assist Dr Boros-Lavack.

25 As I will shortly set out, counsel assisting submits that your Honour would accept that evidence that Joel did receipt very good care for the majority of the time that he was at Mi-Mind, but the problems with the care that he received emerged in the last year in particular that Joel Cauchi was being managed by the Mi-Mind clinic, and particularly there was a failure to fully investigate early warning signs of relapse into psychosis, particularly a failure to adequately explore the concerns expressed by Joel Cauchi's mother, who had proven herself to be a very reliable historian, and a very caring and well placed person in terms of her observations. Most significantly though the failing, the major failing, was a failure to pass on those concerns at handover of Joel Cauchi when he exited the care of Mi-Mind.

40 So even if, as your Honour may accept, Dr Boros-Lavack had convinced herself that they were not the early warning signs of relapse, they were nevertheless very, very significant indicators that needed to be passed on to other persons who would interact with Joel. So although there was very good care for many years, at the pointy end, when Joel's mental health was slipping away and there were what we say are obvious signs that needed to be better investigated, his treated psychiatrist made a very significant error in terms of the handover which had significant consequences for his ongoing care.

50 Can I briefly address the decision made by Dr Boros-Lavack to wean Joel Cauchi off all antipsychotic medication? I've noted that Dr Boros-Lavack saw Joel for the first time in March 2012. On 6 March she saw him with Nurse Moody. Significantly Dr Boros-Lavack recorded a diagnosis for

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Joel Cauchi of chronic paranoid and disorganised schizophrenia, which was in control on clozapine, and that he had OCD.

5 Shortly after Dr Boros-Lavack started treating Mr Cauchi, she began to reduce his dose of clozapine. In March 2012 Joel was on 550 milligrams. In effect Dr Boros-Lavack reduced the quantity, about 25 milligrams per visit. That initial decision was in line with what had been advised in the public sector to reduce the clozapine dose. I've made the point earlier, reduction of the dose was envisaged when Joel was discharged from the public system, but
10 cessation of clozapine was not.

The first dose decreased under Dr Boros-Lavack's care was from 550 milligrams to 525 milligrams of clozapine at night, on 10 April 2012. On that date Dr Boros-Lavack wrote to Dr Grundy including to say that Mr Cauchi
15 "would like to see how he goes on a decreased dose of Clopine." Dr Boros-Lavack stated that Mr Cauchi wanted to find his optimum dose. Again that appears to be in line with what was envisaged in the public sector.

20 Thereafter from 2012 to 2015 Dr Boros-Lavack continued the gradual reduction of the dose Mr Cauchi was taking, and she continued to write back to Dr Grundy to indicate that he was doing well and that his mother thought that he was doing well. On 6 May 2015 Dr Boros-Lavack wrote a letter to Dr Grundy requesting that Joel Cauchi be referred to Dr Nicky Stephens who had been his psychiatrist in the public sector, so that she could get a second
25 opinion.

This request to Dr Grundy assumed some significance in the inquest and I asked that it be put on screen. It's exhibit 1, vol 20, tab 793 of the Mi-Mind records, it also appears in vol 19, tab 788. If you could scroll up please?
30 So that letter, dated 6 May 2015, specifically said that:

"With the advent of Nicky, Dr Stephens, coming to private practice, I've approached her to give a second opinion regarding Clopine. What would be his, Joel's, optimum dose? Could we switch him to another medication, eg optimum dose of Abilify, note this was
35 introduced for Clopine induced OCD. I do believe Joel needs an antipsychotic for long term relapse prevention".

40 So it's clear there that the intention of Dr Boros-Lavack was that Joel continue on some form of antipsychotic which was needed for long-term relapse prevention.

45 On 14 July 2015 Dr Stephens saw Joel Cauchi and she wrote a very helpful letter in reply to Dr Boros-Lavack. That's exhibit 1, vol 20, tab 793, p 234. In it she referred to the need to discuss the potential risks and benefits of stopping clozapine medication with Joel and his mother, and noted that in view of Joel's limited recollection of his positive psychotic symptoms, "the family are most likely to be the people to recognise any early signs of relapse."

50 That reply and the original letter came into sharp focus during the inquest.

5 In her oral evidence, Dr Boros-Lavack stated that at the time of seeking Dr Stephens' second opinion, the goal was exactly as it was set out in her letter to Dr Grundy to find the optimum dose of clozapine, not to ultimately cease an antipsychotic. To either find the optimum dose of clozapine or to exchange clozapine for another antipsychotic, and yet at sometime between July 2015 and June 2019 that plan changed. Over those four years, Dr Boros-Lavack continued to gradually wean Mr Cauchi off clozapine and also ultimately took him off Abilify with no plan for an alternative medication regime.

10 In our submission, no rationale for a change in that management plan is clearly articulated in the notes. There's no contingency plan set out if symptoms returned, and no record of any detailed discussion with Mr Cauchi and his parents as to what symptoms to look out for, in spite of the high risk of relapse, and nowhere is there a record of a discussion of just how high that risk of
15 relapse was. On 28 June 2018, a therapy event termination of treatment form was completed by Dr Boros-Lavack which was to be provided to the Clopine Central. It stated that Mr Cauchi had "recovered from his first episode of psychosis with no relapse over the past 16 years" and that there had been no precipitating event "except discontinuation of clozapine due to successful
20 treatment." 16 years takes us back to 2002.

The suggestion that there had been no relapse over those 16 years is not correct. The suggestion that is made in that letter of a recovery from first episode psychosis with no relapse over the past 16 years is simply not correct,
25 and it misrepresents the true extent of Joel's illness. First, even in the public sector while he was carefully managed from 2001 to 2012, Joel had experienced hallucinations in 2005 and 2007 and 8 that were alarming.

30 Second, from 2012 until June 2019, Professor Nielssen opined, and Professor Heffernan agreed, that Mr Cauchi's symptoms seemed to be chronic cognitive symptoms, and the negative symptoms were there. They also say there were "very likely low levels of hallucinations, although they're not documented, and continuing symptoms of OCD." Third, all psychiatrists on the expert panel, and ultimately Dr Boros-Lavack, agreed that Joel continued to have negative and
35 cognitive symptoms of his psychosis.

In her oral evidence, Dr Boros-Lavack indicated that she initially diagnosed Mr Cauchi as a working diagnosis with chronic treatment resistant schizophrenia, paranoid and disorganised. However, she said after she
40 received a letter and discharge summary from the hospital and public health team, she revised that diagnosis to first episode psychoses which remitted on clozapine. Dr Boros-Lavack indicated in her oral evidence that the first episode lasted for a long period of time until 2008. But the effect of that letter to Clopine Central is very much to suggest that there was a first episode of
45 psychosis that Mr Cauchi had recovered from after successful treatment, given it had no relapse, according to that letter, over 16 years.

Counsel assisting submitted to your Honour in written submissions that the characterisation of Joel Cauchi's illness as a first episode psychosis by
50 Dr Boros-Lavack was at best misconceived. But counsel assisting also

submitted that it was more likely deliberately disingenuous, and further that it was put forward by Dr Boros-Lavack to justify why she was able to wean him off all medication and to try and justify the claim she made on the first day of giving evidence that Mr Cauchi was not unwell when he committed these
5 terrible acts of violence on 13 April 2024. Counsel for the families embrace the submission made by counsel assisting.

Unsurprisingly, Dr Boros-Lavack does not, and in fact objects in the strongest terms. It's submitted on her behalf that, in effect - I'm summarising - first
10 Dr Boros-Lavack used the term "first episode psychosis" but it's an issue with terminology. That is, she was never intending to suggest in this Court that Joel Cauchi's form of schizophrenia was not a chronic condition. Secondly, it's suggested that Dr Boros-Lavack did not in fact give evidence that Mr Cauchi was not unwell when he committed the acts of violence on 13 April. Your
15 Honour, counsel assisting disagrees. That's an important point that I need to clarify in reply.

First, with respect to the use of terminology, Dr Boros-Lavack gave evidence that was confusing and wildly inconsistent at times. But she initially made the
20 claim about first episode psychosis in the context of arguing that Joel's symptoms had resolved by the time she weaned him off clozapine and eventually Abilify. Counsel assisting supports the submission made by or on behalf of the families of Ms Singleton, Ms Young and Ms Good, and likely supported by other families that are set out from para 4.7 of the submissions
25 signed by Ms Chrysanthou SC.

They say Dr Boros-Lavack's evidence also revealed contradictions. In March 2012 she wrote to Dr Grundy diagnosing Joel with "chronic paranoid and disorganised schizophrenia in control on Clopine, OCD". When questioned
30 she admitted that she had "erred on the side of safety", but acknowledged Mr Cauchi had ongoing negative and cognitive symptoms of schizophrenia. Despite this, in her first statement to the inquest she asserted "Joel did not have chronic schizophrenia and he maintained a complete late phase recovery from his single first episode of schizophrenia." That in that written statement
35 was the first time Dr Boros-Lavack had characterise Mr Cauchi's illness as "single first episode of schizophrenia".

Counsel assisting maintains that this was an attempt to reconstruct what was in fact the real diagnosis to fit the narrative that Dr Boros-Lavack tried to
40 maintain for at least part of her evidence. Counsel for Dr Boros-Lavack submits at para 5.22 of the written submissions "while it's fair to say that each of the experts did not agree with Dr Boros-Lavack's diagnosis of prolonged first episode schizophrenia, it is by far from clear that the use of the terms
45 'treatment resistant schizophrenia and chronic schizophrenia' have widely accepted definitions."

We agree with respect, and we suggest the need for a recommendation to clarify that, and in fact the need for detailed guidelines on managing patients with schizophrenia that give much clearer guidance to psychiatrists and GPs
50 who are managing patients on clozapine, including with respect to terminology.

But that doesn't alter the fact that Dr Boros-Lavack, we submit, was attempting to give the impression to the Court, at least for some part of her evidence, that Mr Cauchi had fully recovered from an initial episode of schizophrenia that justified her subsequent decision making.

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Counsel for Dr Boros-Lavack attempted to persuade your Honour that she was not recharacterizing the illness, and that rather that's a result of confusion around terminology. Counsel assisting says that that is not persuasive when looked at in context, we submit although her evidence was inconsistent it was clearly an attempt to recharacterize the illness at times, but that's a matter for your Honour. Second, in relation to the submission on behalf of Dr Boros-Lavack that they reject what was said in our submissions, and they say Dr Boros-Lavack "never offered an opinion that Joel was not unwell when he acted so violently", counsel assisting simply does not understand that submission.

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It flies in the face of what she said on the first day of her evidence and her retraction of the evidence the very next morning. The entire exchange is set out in the submissions of Dr Boros-Lavack, and we submit makes the point made by counsel assisting. At para 5.13, it includes this evidence, and I hope it won't cause upset if I repeat it, but I'll only do it briefly. Dr Boros-Lavack said on the first day of evidence:

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"I honestly believe that his - that is my opinion that was nothing to do with psychosis. He couldn't have been organised to do what he did. I think it might've been - might've been due to his frustration, sexual frustration, pornography and hatred towards women. That is my opinion."

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It was pointed out to Dr Boros-Lavack by counsel assisting that the view of the expert psychiatric panel was that Joel was suffering from psychosis on 13 April and she was asked if she disagreed. She replied "on that point yes" and went on to say that he was too organised to have been psychotic. That was the clear understanding of those in Court for that evidence, including families and indeed the media. It was the clear understanding that Dr Boros-Lavack was trying to suggest that Mr Cauchi was not mentally unwell and was in fact motivated by malice.

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Mr Lynch objected to the question asked of his client, in fact objected at the time his client started answering the question, but it was an answer she obviously wanted to give. The answer was shocking. It was genuinely shocking, and Dr Boros-Lavack resiled from it the next day, as she should. It's to her credit that she resiled from it. But your Honour would accept the submission made on behalf of the Good, Singleton and Young families from para 4.49 of their submissions, that "it was only after Ms Chrysanthou SC pressed Dr Boros-Lavack further that she withdrew that evidence."

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"In the families' submission, the fact such evidence was given at all demonstrates that Dr Boros-Lavack went to considerable efforts to attempt to distance Mr Cauchi's acts from her treatment decisions." They go on to tell your Honour that "Dr Boros-Lavack's conjecture that Mr Cauchi committed

these terrible crimes because of sexual frustration and hatred towards women was regrettable. The evidence was widely reported by press, it caused great distress to the families.” They quote counsel assisting referring to the primacy that the coronial jurisdiction places on “therapeutic jurisprudence”, and then they tell your Honour this:

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"Therapeutic jurisprudence acknowledges that legal processes can affect the wellbeing of participants, and that they can be conducted in a manner that may assist with the process of grief and healing rather than retraumatise those who are so directly affected."

They tell your Honour that Dr Boros-Lavack's evidence referred to in that preceding paragraph further traumatised the families. In my respectful submission, she should've given much greater thought to it before she came out with that conjecture. Each of the expert psychiatrists who gave evidence before the inquest agreed that Mr Cauchi suffered chronic schizophrenia and that he was experiencing an acute episode of psychosis on 13 April 2024 after a period of decline. He was experiencing that psychosis when he committed these terrible acts of violence, and his behaviour was utterly inconsistent with the person who he was when he was well.

That's clear from the evidence of his parents, other family members, friends, the nurses at the Mi-Mind clinic and Dr Boros-Lavack herself. That was ultimately accepted by Dr Boros-Lavack in oral evidence and indeed in written submissions, but her initial denial does her no favours. Her defensive response suggests a lack of insight, and that we submit is relevant to your Honour's decision whether to refer Dr Boros-Lavack to a regulatory body, which is a submission made by the families and to which I will return.

Another issue of contention was how long the levels of clozapine were likely to have been subtherapeutic for Joel, given that he was weaned off that medication slowly but ultimately to a very low level. One point made by Dr Boros-Lavack to justify her decision to wean Joel off clozapine was the fact that he had been on what she described as "subtherapeutic levels of clozapine" for many years prior to 2018 and he had not become unwell over that period of time.

On 9 April 2013, for example, Joel's clozapine concentration was 290 ug/l, I think that's micrograms per litre, it's below what she regarded as a therapeutic level. Dr Boros-Lavack gave evidence that “by this time, his level was subtherapeutic for both treatment and long-term relapse prevention of his treatment resistant schizophrenia. This suggested that his single episode treatment resistant schizophrenia had already been in late phase recovery, and from this point on a relapse could've occurred. The clozapine doses he was taking from 2013 until 2018 were not likely to have had antipsychotic efficacy because the levels were subtherapeutic.” She says that is a reduced dose that's “unlikely to have had any therapeutic or beneficial impact, or only a possibly minor therapeutic beneficial impact beyond any placebo effect.”

“The significance of Joel taking only subtherapeutic levels of clozapine for

5 some four years or more prior to ceasing it altogether is that his condition was stable and improving without the need for therapeutic levels of the medication. This suggests that the medication may not have been necessary for maintaining his mental health during that period,” and she went on to say that “the fact that his condition was continuing to improve without relapse symptoms between 2014 and 2018, reinforced the plan she had to wean him off clozapine altogether.”

10 Relatedly, she says, the “low dose Abilify of 5 milligrams in the morning was a subtherapeutic dose for both treatment and long-term relapse prevention of his schizophrenia.” That position received some support from Professor Large. Counsel assisting submit that it should be rejected as a justification for ceasing clozapine. In summary, first, as Professor Harris and Dr Nielssen explained, even low doses of clozapine and olanzapine can have therapeutic effect. It's true that at some point it would have become subtherapeutic, but it's certainly not as easy to determine when, and not possible to say that it was ineffective from as early as 2013 and 2014.

20 Second, Joel was never free of the negative and cognitive symptoms or of OCD between 2014 and 2018, and there are numerous examples in the records of debilitating symptoms.

25 Third, Dr Boros-Lavack's evidence that low dose Abilify of 5 milligrams in the morning was a subtherapeutic dose is frankly confusing when that is the dose that Dr Boros-Lavack says she put him on when she was concerned about a relapse in 2019. And I'll come back to that evidence shortly.

30 In any event, counsel assisting submits that your Honour would not be critical of Dr Boros-Lavack for trialling a cessation of clozapine or even Abilify in spite of the obvious risk. The real problem, we say, was the failure to fully understand the risk to Joel of ceasing that medication, the failure to take adequate action when the symptoms returned, including by preparing a proper handover, and the failure to clearly document a communication of that risk.

35 in relation to this issue of whether or not Dr Boros-Lavack did adequately monitor the risk of relapse, there was some contention that needs to be teased out here in the written submissions of counsel assisting and the submissions on behalf of Dr Boros-Lavack. Counsel for Dr Boros-Lavack rightly makes the point that there must be a balance between patient autonomy on the one hand and the need to safeguard patients and community from persons at risk to themselves or others. That's accepted of course. But psychiatrists managing a patient with chronic treatment resistant schizophrenia are in a position of great trust and they have an enormous responsibility.

45 That responsibility includes understanding the risk to patients and the community of ceasing antipsychotic medication, communicating that risk effectively to the patient and carers, responding appropriately and with a high index of suspicion when the evidence of relapse is presented, handing over any possible early warning signs. With respect to whether or not
50 Dr Boros-Lavack understood the high risk of relapse, it's just simply unclear

because of the confused nature of the evidence that she gave.

5 In our written submissions, counsel assisting point to evidence that we thought
Dr Boros-Lavack gave when she said at one point in her evidence that around
14% of people with first episode psychosis will relapse. Counsel assisting then
pointed out that that's in stark contrast to the evidence of the expert panel,
particularly articulated by Heffernan and Nielssen, that it's more likely around
80 or 90% of patients who will relapse if they become unmedicated. To us as
10 counsel assisting, the use of that statistic from Dr Boros-Lavack suggested that
she did not appreciate the risk before she weaned Joel off the medication.

15 However, on behalf of Dr Boros-Lavack it's rightly pointed out that counsel
assisting neglected other points in the evidence where Dr Boros-Lavack gave
an explanation about risk where she in fact reversed the percentages. That is,
where she stated that only 14% of persons suffering first episode psychosis
will not relapse. And Mr Lynch on her behalf points that out at 6.3 to 6.7 of his
submissions.

20 In our submission, your Honour should take the evidence of Dr Boros-Lavack
at its highest, that is, give it the greatest benefit to her that it should get, accept
then that she did mean to suggest that she understood that 14% will not
relapse, meaning 86% will. She understood at the time that she weaned Joel
off medication that 86% of those persons with first episode psychosis would
relapse.

25 However, your Honour, if that's right, it begs the question why did she not
place more weight on the concerns raised by Joel's mother, particularly after
October 2019, and it makes it even more confounding that although she
initially thought they were early warning signs and that Joel should
30 recommence Abilify, she quickly dismissed the concerns when he expressed
a reluctance to resume the medication and in circumstances where Mi-Mind
staff did not see psychosis during relatively short consultations.

35 If Dr Boros-Lavack did understand the risk that 86% of persons with first
episode psychosis will relapse, it's even more strange that she did not
document an explanation of the risk to Joel once the symptoms emerged, why
she didn't do more to persuade Joel to resume the medications as Dr Nielssen
suggested she could have done, and why she didn't hand over the symptoms
and the risk to Dr Grundy when Joel was discharged. Not once during that
40 handover or discharge process did she articulate the risk or the concerns or
what could be done to mitigate the risk.

45 On 28 June 2018, the same day that the termination of treatment form was
completed by Dr Boros-Lavack, she saw Joel with Andrew Cauchi present.
Dr Boros-Lavack noted that he was doing well after not taking clozapine for
a month, although the evidence suggests that in fact Joel did continue to take
clozapine up to 28 June at the request of Mrs Cauchi, which was agreed to by
Dr Boros-Lavack, because they had an upcoming holiday. Dr Boros-Lavack
50 recorded that Andrw Cauchi had grandiose religious delusions but was not
psychotic.

5 Reflecting on the risk of relapse, Professor Nordentoft gave evidence that a clinician should have been aware that Mr Cauchi's father had experienced psychoses at times and that being unmedicated may be an ongoing risk factor for Joel.

10 As senior counsel for Dr Grundy points out in her submissions, from 2012 to the time of discharging Joel in early 2020, letters were sent back from Dr Boros-Lavack to Dr Grundy that conveyed to him, first, that Joel was doing very well while the clozapine was gradually being reduced, and second, that his mother was fully supportive and had no concerns. That's what makes the action and inaction of Dr Boros-Lavack after November 2018, and particularly after October 2019, so confounding. Because after October 2019 in particular there were early warning signs that we say were red flags requiring clear
15 action and explanation to Joel and his parents, and certainly clear communication with the general practitioner who is expected to take over care when Joel was discharged in 2020.

20 No one could have foreseen the tragic events of 13 April. It's not suggested that Dr Boros-Lavack could. But for any person suffering schizophrenia who has experienced the disabling consequences of psychoses as Joel had, which included anger, violence, terrible hallucinations - auditory, visual and olfactory - suicidality and clear torment, the consequences of a relapse would be catastrophic. Your Honour heard evidence that each time a patient like that
25 relapsed, there is damage that is done.

30 On 19 November 2018, Mr Cauchi moved out of his family home for the first time and into a unit, a period that was likely to be stressful. Mrs Michele Cauchi links his decision to move out to him wanting to cease medication. Mi-Mind notes records that Michele Cauchi was worried that Joel wouldn't be able to look after himself and would need more support, but she was trying to give him the independence that he wanted.

35 On 28 November 2018, Michele Cauchi called the Mi-Mind Centre and she indicated that she was concerned. Dr Boros-Lavack saw Joel and recorded a note. That's at exhibit 1, vol 20, tab 793. It's recorded there that Joel's mental state was apsychotic, euthymic, that is stable, but exhausted with a new mannerism or complex tic or frowning towards the right and then bringing his gaze back into the conversation like he was responding to
40 a non-apparent stimulus. Volume 20, tab 793, p 36.

45 When confronted, Joel was grateful. He explained his behaviour of fighting with breaking down emotionally, and then he cried with his head down from exhaustion, as if he'd been well aware of doing too much. At that stage he was still taking Abilify at 5 milligrams in the morning, but on Dr Boros-Lavack's evidence, she regarded that as a subtherapeutic dose. She noted he was responding well to counselling, and the plan was just to continue the Abilify 5 milligrams.

50 On the same date at 6.14, Nurse Brooks recorded a note after seeing Joel that

5 he seemed out of sorts and was apparently upset after his appointment with Dr Boros-Lavack, and that was discussed with Dr Boros-Lavack. With the benefit of hindsight, on that date, November 2018, it may be the first indication that Joel was experiencing the early warning signs that should have triggered careful review by Dr Boros-Lavack, including discussion with Joel's close family members as to what they were observing and feedback to the family and general practitioners. But of course, it's accepted that a one-off distressing incident from Joel would not be enough.

10 Seven months later on 12 June 2019, Dr Boros-Lavack saw Joel with Michelle present, and the plan recorded was collaboratively decide to stop Abilify 5 milligrams in the morning, to continue with no psychotropics at all and to continue with timely follow up. Counsel assisting accept that there were factors pointing in different directions as to whether or not Joel was declining at that time, but given the high risk of relapse, Dr Boros-Lavack should have had a high index of suspicion that he may be within the 86% of patients who experience a relapse, and that situation became much more pronounced from October 2019.

20 Your Honour, our written submissions set out in detail that from at least 17 October 2019 onwards, so approximately four months after ceasing all antipsychotic medication, there were significant red flags that pointed to relapse. The main issues can only be summarised here orally, but they're set out in detail in written submissions.

25 On the morning of 17 October, Joel called the Mi-Mind Centre and cancelled his scheduled appointment for that afternoon, saying that he was unwell. Although a note made by the person taking the call recorded that he did not seem sick. Joel then rang the Mi-Mind Centre again and requested to continue with his appointment. Michelle called and said that she was concerned for his mental health and physical health and that she had told her son to keep the appointment.

35 On around 6 November, Joel met with a male peer support worker, Mr Magin, who worked at the Mi-Mind Centre. He recalled Joel telling him that he had sexual urges that he wanted to control, because the urges were against his religion. He wanted to restrict access to the internet, mainly pornography, on his devices. Mr Magin passed that on to one of the Mi-Mind nurses.

40 The next day on 7 November, Ms Cauchi saw a nurse at the Mi-Mind Centre. He reported that he met with a peer support worker the previous day and they were working on some things, including overcoming sexual concerns, but he was unwilling to elaborate at that time and he felt uncomfortable talking to a female about it.

45 On 12 November, Joel emailed the Mi-Mind reception - and I'll just ask that that come on the screen. It's Exhibit 1, Vol 20, Tab 793, p. 142. He said - "tech ideas" was the subject heading:

50 "Hi, can we please cover some ideas for a porn free phone and

5 other devices, currently using hotspot, on Thursday. I will consider a porn free ISP if the cost is reasonable as well. If seeing a specialist is what you recommend, I will consider that the same. I want a totally porn free internet on my devices if possible, on all browsers and potential browsers, Xbox One X, and for it include images too. Thanks, Joel".

10 Two days later Dr Boros-Lavack and a nurse - that's Nurse McCullough in Nurse Brooks' absence - saw Joel. Dr Boros-Lavack's note records, "Insomniac. No psychoses. Accepted a short dose of Zopiclone for sleep". The nurse's note recorded, amongst other things, that he denied psychoses, reported there were issues with his sleep and low energy, but kept looking to the side when he was in conversation, an occasional tic was present and he wants to stop the use of pornography because it's opposed to religious beliefs.

15 They discussed the email that Joel had sent.

20 The expert panel generally agreed that the significance of what Joel was telling the Mi-Mind staff at that time was that he wanted to remove the pornography access from his devices, because it suggested some sort of compulsion and importantly that it conflicted with his religious beliefs, which was likely to cause stress. Professors Large and Nordentoft told the Court that decreased libido is a common side effect of antipsychotic medication, so it's likely that Joel experienced an emergence of sex drive once he stopped the antipsychotic medication, and the significance was that that was causing Joel stress.

25 It's extremely sad when you reflect on the way that compulsion eventuated for Joel Cauchi over the years later, where he accessed as we know an excessive quantity of porn, much of it very disturbing, and yet you have him as a patient in 2019 asking for help to remove access from his devices, saying he's willing to see a specialist if that's what it takes, talking to the peer support worker, and being open with his psychiatrist and nurse about the torment that is causing him, because it conflicts with his religious beliefs.

30

35 On 20 November 2019 there's a hugely significant communication from Joel's mother, so I'll ask that that go on the screen, it's Tab 793 of the Mi-Mind records, p. 141. I won't read it all out on the screen, but it was the subject of some examination. Michelle Cauchi sets out there that Joel was not doing very well since going off Abilify. She says:

40 "I know you thought it wasn't having any effect, but I have noticed a gradual decline in his condition, and judging from notes on paper he's left around the place in the past week, I have a feeling he's now hearing voices et cetera. He's very distracted, forgetful, his OCD is getting out of hand with him going through half a cake of soap in the shower. Found out last week he lost his job. I'd hate to see him go

45 back into hospital after 20 years of being stable when on medication, but of course being off it has made him realise how sedating it was, although I think that was the clozapine that did that and not the Abilify. Also he's at a loose end now that he has

50 finished study".

And this important line:

5 "He quite possibly won't let on what's going on in his head, but
I think you need to know how he is. I would appreciate it if you
would tell him I haven't 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 successfully live
10 independently and be doing as well as he was a year ago when he
moved out of home".

Joel Cauchi had hopes and dreams for his life and his parents had hopes and
dreams for his life and they were there to support him.

15 On that same day Michelle called and she spoke to Nurse Brooks, and
Nurse Brooks made a note of the conversation. I don't have to put it up on
screen, it's very similar to that, but it notes the extreme symptoms that Michelle
was noticing. She says:

20 "He's having extreme OCD with showering and washing himself.
He's writing a lot of notes, plus plus plus, at home and leaving them
about. Mother read some of the notes with some content of under
satanic control, of religious themes, desire for porn conflicting with
his religious beliefs and wanting no access to porn sites to prevent
25 temptation. Leaving his phone with his mother at home overnight so
as not to use his phone and internet for porn sites. Mother reports
'He's walking funny, change in his gait'. He reports he's afraid of
getting sick and wearing on layers of clothes to prevent him getting
sick. He bends his head a lot, has odd movements".

30 With respect to that behaviour described or reported by Michelle Cauchi on
20 November, Professor Harris opined:

35 "They suggest he's having a relapse, that he's having changes in
his behaviour that suggest not only positive symptoms but a relapse
of his obsessional symptoms, but also of the movement disorder
that is highlighted earlier by Professor Heffernan as one of the
symptoms of psychoses".

40 Professor Nordentoft also expressed the opinion that it was really concerning
that Joel was experiencing exactly the same symptoms as he had done when
he was first hospitalised in January 2001. I pause to note that they are also
similar symptoms to those that emerged when he was noted to be unwell in
45 2005 and later 2007 and 2008. So it's an emergence of satanic themes or
themes of being possessed or worried or tormented by the devil.

Counsel assisting commends that evidence to your Honour and says that it's
inescapable that they were signs of relapse. On 21 November
Dr Boros-Lavack recorded a plan at 8.36am to prescribe Joel Abilify tablets,
50 10 milligrams, one table in the morning. The prescription history in the

Mi-Mind Centre records also say provide Abilify in the morning at that quantity. That action and dose is consistent with the evidence of Dr Boros-Lavack that she initially did suspect there was a relapse.

5 However in oral evidence Dr Boros-Lavack said that recording 10 milligrams was a typographical error that she made, and that it was conveyed to Joel, and she says he understood, that he was only to take half a tablet, 5 milligrams, consistent with his previous dosage. In our respectful submission your Honour that can't be reconciled with earlier evidence that 5 milligrams was a
10 sub-therapeutic dose, or with what appears in the letter that she clearly said to Michele that that dosage was not having any effect.

15 Either Dr Boros-Lavack did intend 10 milligrams, because she recognised that there had been a relapse, or she intended to give him a dose that she now says was sub-therapeutic and that she regarded at the time as sub-therapeutic. So that evidence is frankly confusing. Professor Harris stated that aripiprazole at 10 milligrams would've been the standard dose to commence for someone with schizophrenia, who was not on medication and who was experiencing what appeared to be relapse. Professor Nordentoft
20 agreed but said 5 milligrams was better than nothing.

25 On the same date at 11.19am a note of Nurse Brooks indicates that she saw Joel face-to-face on his own and that note recorded that Joel denied hallucinations or delusional, that she spoke to his father, Andrew, and gave him some information about what Joel was experiencing and the suggestion that he should go back on medication, and that Andrew Cauchi was adamant that he did not want his son going on medication because he thought it would kill him, and his father told her that he himself had been traumatised by
30 demons when awake and hears voices and is not on medication.

35 Nurse Brooks wrote that Joel was unable to answer questions, he had long wordy replies, skirting answers, he had some facial tics and glances to his right, and the plan was that Joel would self-monitor and self-determine if he would restart the medication. Regarding Joel's father's response, Professor Heffernan indicated that is Andrew Cauchi didn't want Joel to go back on medication, that would be a powerful message for Joel.

40 In her oral evidence Dr Boros-Lavack indicated that she re-prescribed Abilify for Joel, because she did think at the time that there were, or possibly were, early warning signs of relapse, but that she later believed that the early warning signs of relapse resolved once Joel's fear of contracting a sexually transmitted disease resolved, and she said that it was ultimately her belief that it was not an early warning sign of relapse. It was based on fear of an STD and sexual frustration.

45 On 28 November 2019 Dr Boros-Lavack saw Joel with Nurse Brooks. His mother was contacted by telephone and she was keen, his mother, for Joel to restart Abilify for relapse prevention based on his early warning signs. A note was taken that Joel was not keen to start Abilify because of the dysphoric feelings he'd had on it in the past, but he was happy to restart Rexulti, another
50

antipsychotic, if not going well mentally to prevent relapse of schizophrenia. The plan then recorded was to start Rexulti, 1 milligram in the morning one week, and then 2 milligrams, and he was given a trial pack when ready for the early warning signs.

5

On 5 December Nurse Brooks recorded that she advised Mrs Cauchi, Michelle, that Joel is to start taking the Rexulti medication today and to consider his compliance and adherence to the doctor's management. Nurse Brooks gave evidence that she wanted Joel to start taking that medication and she thought he should. But Joel then re-called and said he wanted to speak to Dr Boros-Lavack about that, because he was reluctant to take the drug and he felt well.

10

Nurse Brooks called Michelle again and said that Joel would not be advised to recommence the medication, but was encouraged to do so if he noticed any warning signs or deterioration. She said that she didn't have any specific concerns regarding the decision then not to recommence Mr Cauchi on antipsychotic medication, because it was based on clinical presentation and his preference at that time. It's not suggested that it was the responsibility of the nurses to determine whether or not that medication should be prescribed or how persuasively they should communicate that to Joel; that was a decision for Dr Boros-Lavack.

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I pause to note that the evidence from Nicky Stephens looms large here, back in - I withdraw that - the letter from Nicky Stephens, back in 2015. That because Joel himself may not recall those positive symptoms, his family may be best placed to alert the doctors in relation to those symptoms, and so they were. Michelle Cauchi's concerns were clearly expressed by her in writing, orally, as often as she could.

30

On 8 January 2020 Dr Boros-Lavack and Nurse Brooks saw Joel. Dr Boros-Lavack's note indicates that he was totally well and the plan was to continue with no medications. On 28 January Joel sent a Skype message to another psychiatrist at the practice, Dr Alempijevic, stating "Hey, do you do advice for men's sexual performance at all". The doctor didn't respond but told Dr Boros-Lavack about the message.

35

On 12 February 2020 Joel attended his final face-to-face appointment at Mi-Mind with Nurse Brooks and she recorded no evidence of psychoses on examination. Joel asked her to speak to a therapist because he was experiencing a lack of confidence with sexual knowledge. On 14 February Michelle phone the Mi-Mind Centre again to express further concerns about Joel, including that he was not well and that she thought he might become homeless if he moved to Brisbane. That's the final slide that I ask that go on. It's Mi-Mind records, Tab 793, pp. 19 to 20.

40

45

She called to express her concerns about Joel's functioning at home and his probable move to Brisbane. She said "His self-care is poor, that his father went round there to put the bins out, the place was a mess, there were dishes in the sink and mess everywhere. He appears more isolated and irritable and

50

is occasionally swearing". Again she didn't want Joel to know that she called because she won't be able to address those issues with him if that was the case, and a joint appointment was offered. The nurse also said he could be re-referred to peer support programme but advised that there was a waiting list. Nurse Schwarz gave evidence that she passed on Ms Cauchi's concerns to Dr Boros-Lavack. Again, Dr Stephens' letter, 2015, that the mother will be best placed to observe that in circumstances where Joel might not recall how unwell he became.

10 I come to the final topic here and that's the discharge of Joel and the handover to Dr Grundy. On 17 February 2020 Joel attended his final appointment with Dr Boros-Lavack via Skype. Dr Boros-Lavack hadn't seen him in person for about three months, since 28 November. Dr Boros-Lavack considered that he had no signs or symptoms of a psychiatric disorder at that time when she saw him over Skype. They discussed that he was sexually frustrated and looking for a casual relationship. He also wanted private rental and work in Brisbane.

The plan recorded included continued monitoring by Skype, no medication, for follow-up in a month. They agreed at that stage that he could be continually monitored monthly and supported when he moved to Brisbane. Professor Nordentoft was asked whether it was reasonable to consider that Joel was well by that period of time, on 17 February, given the signs that had been indicated. She opined "I think it is too superficial an evaluation where the mother's concern is not taken into consideration to a sufficient degree". Counsel assisting submits that your Honour would accept that opinion.

There was no evidence of any discussion about the concerns he'd previously articulated with pornography. There was no evidence of raising a visual and auditory hallucinations that had been recorded or reported by the mother, that didn't necessarily require saying that the mother had seen them, but just asking Joel about those symptoms and advising Joel about the risk and recording it. There's no discussion there recorded about the OCD being raised.

35 On or about 15 March Joel moved from Toowoomba to a share house in Brisbane. On 16 March Joel attempted to attend a Skype appointment with Dr Boros-Lavack but it's recorded that there was no sound, and while they were trying to get the Skype appointment to work, Joel advised the receptionist at Mi-Mind that he was living in Brisbane. The receptionist then called Joel and told him that he would need to be referred to a GP in Brisbane, because there was no way of Mi-Mind being rebated for Skype calls when he was in a different jurisdiction away from Toowoomba. There's no evidence of any phone call from Dr Boros-Lavack to Joel to sign off or explain her handover, after some eight years of being his psychiatrist. There was no referral to a GP in Brisbane, but rather back to the GP in Toowoomba, Dr Grundy.

We're at 11.15 might I continue so that we finish this section, or does your Honour think that there needs to be break at this point in time?

50 HER HONOUR: Unless anyone particularly needs a break? Keep going,

thanks.

5 DWYER: I'll go through until 11.30 and I'll try and speak quickly so we can
move onto the next sections. On 19 March 2020 the receptionist using
a precedent wrote to Dr Grundy and Dr Boros-Lavack signed the letter. His
practice is notably located in Toowoomba and not in Brisbane. I'll quickly put
the letter on the slide. It's at p. 113 Tab 793. It was the subject of significant
evidence. In her oral evidence Dr Boros-Lavack indicated that she actually
10 spoke to Dr Grundy via telephone after sending the discharge letter, and that
Dr Grundy may or may not have said that he would recall Mr Cauchi. Your
Honour will remember the evidence in this regard. The letter says:

15 "I've received advice from Medicare regarding the parameters of the
Skype eligibility. Unfortunately, Joel has moved recently and currently
resides in an ineligible Skype area, and as such I'm no longer able to
offer Skype appointments. My receptionist has contacted Joel to advise
him of this change. Joel has indicated he'll be unable to attend face to
face appointments because of the distance".

20 These words, which assume some significance:

"I'm therefore discharging Joel back into his and your kind ongoing care.
Please recall Joel to discuss his options and referral to an alternate
psychiatrist if required. In the future, should Joel move into a Skype
25 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".

30 Dr Boros-Lavack acknowledges now in written submissions that there is
ambiguity in the language used, because the sentence that assumes some
significance can be read in a different way "Please recall Joel to discuss his
options and referral to an alternate psychiatrist if required", could be please
recall him if he's required to be referred to an alternate psychiatrist. Or it could
be read "Please recall Joel, to discuss his options and referral to an alternate
psychiatrist if required".

35 As I say, in oral evidence Dr Boros-Lavack indicated that she remembers
actually speaking to Dr Grundy after sending that discharge letter. By contrast,
Dr Grundy confirmed that he has no recollection of a phone call to
Dr Boros-Lavack and does not believe that such a call took place. In his oral
40 evidence, Dr Grundy indicated that he didn't recall Mr Cauchi, because he
believed all was well and that Joel was able to return to the practice of his own
accord particularly because he always had made his own appointments when
he had health concerns.

45 For the reasons set out in the submissions of Ms Mathur SC and
Ms Chrysanthou SC, your Honour would not accept Dr Boros-Lavack's
evidence that she called Dr Grundy and spoke to him on the phone. But in any
event, your Honour may think you don't have to decide that issue, because
even if she did call him, she did not pass on the crucial information about
50 Joel's mother's concerns of decline over the last five months. You can

confidently conclude that because she herself had dismissed any likely concerns.

5 Counsel assisting maintain that there are three problems with that referral process being, first the referral was to a GP in Toowoomba, not a GP in Brisbane and no effort was made to refer Joel to a GP in Brisbane. Second, there was no indication that Joel would need ongoing monitoring by a psychiatrist, and there was that ambiguous language used. Third, the letter to Dr Grundy does not refer to the recent concerns expressed by Michelle that he might be hearing voices, that she'd found satanic notes, that she noticed a change his gait, et cetera.

10
15 Neither does Dr Boros-Lavack suggest that she handed that over in a telephone call if she didn't want any record of it. That was particularly problematic in circumstances where every letter that had gone back to Dr Grundy over the eight years prior had indicated that Joel was doing very well and that Michelle Cauchi believed he was doing very well. There are belated concessions made on behalf of Dr Boros-Lavack in the written submissions signed by Mr Lynch at 13.6 to 13.8. Those concessions related to the transfer or handover process. That includes that in those written submissions, it is written:

25 "Since concluding her oral evidence Dr Boros-Lavack has had the opportunity to reflect on the oral evidence of the eminent panel of expert psychiatrists, and her own initial resistance in her oral evidence to acknowledge that there were some flaws in the process whereby she discharged Joel back to his referring general practitioner Dr Grundy, I am instructed that she now does concede that there were deficiencies in the manner she discharged Joel from her care.

30 Dr Boros-Lavack accepts that the wording of her discharge letter to the referring GP Dr Grundy represented a missed opportunity for a more comprehensive handover. The letter's primary purpose was to communicate the abrupt nonclinical reason for the cessation of her care. It was an alert that the existing care structure had collapsed and a new one needed to be built. Dr Grundy had received regular detailed updates for eight years and was well versed in Mr Cauchi's condition.

40 Dr Boros-Lavack now recognises that her discharge letter should have mentioned that in response to potential early warning signs identified by Mrs Cauchi in November 2019 which has proposed Mr Cauchi resume antipsychotic medication Abilify or Rexulti which he declined, Dr Boros-Lavack now recognises her discharge letter to Dr Grundy should have referenced the high risk of relapse for Mr Cauchi while off antipsychotic medication, and she accepts the criticism that she did not update or confirm her guidance with Dr Grundy regarding this risk".

50 I pause to note two things. Firstly, that that concession made on her behalf, albeit belated is welcomed. We don't accept that Dr Grundy was well versed in Mr Cauchi's condition, because he was not, given the nature of the letters that

had gone back to him. Counsel assisting submits that although that is welcome, your Honour may not be satisfied that it is reflective of any genuine insight on Dr Boros-Lavack's behalf. It might be, but it can't be tested.

5 The questions that were asked by myself as counsel assisting of
Dr Boros-Lavack about these issues are set out conveniently in the
submissions of Ms Chrysanthou SC from paras 4.60 to 4.62. It will be a matter
for your Honour, but it's submitted by counsel assisting that those questions
10 were asked of her politely, calmly, and they came after repeated pleas not to
talk over counsel assisting. Dr Boros-Lavack had every opportunity to make
appropriate concessions while she was giving evidence, and she did not.
In her oral evidence, Dr Boros-Lavack presented as lacking in insight and
belligerent. It's hugely concerning that a psychiatrist charged with the
responsibility for some of the most vulnerable in the community would be so
15 unwilling to reflect and learn at that time.

Her belated insight is preferrable to no insight, if it indeed represents her
views, but it can't be tested. I make that submission in sorrow, not because it
gives counsel assisting any pleasure to be critical of an individual psychiatrist
20 tasked with this very difficult role. But it was exceptional, the level of
belligerence and confrontation that Dr Boros-Lavack demonstrated in the
witness box. The key findings that the Court should make are set out in the
submissions of counsel assisting at paras 531 to 541. We don't resile from
those submissions, save for the concession that Dr Boros-Lavack may well
25 have understood the risk of relapse to be 86% and not 14%.

It's never been suggested by counsel assisting that Mr Cauchi could or should
have been scheduled in February 2020, but the concerns raised by Michelle
Cauchi should have been given greater weight, they should have rung alarm
30 bells more, they called for deeper investigation. More effort could've been
made to encourage Mr Cauchi to resume his medication, given their long
relationship as Dr Nielssen alluded to. But at the very least and of greatest
concern is the handover. The failures in the handover in 2020 had
ramifications longer term. A submission is made by families that your Honour
35 should make a referral of Dr Boros-Lavack to the relevant regulator.

That is a matter for your Honour, but counsel assisting says it's open to your
Honour and that the level of insight and the lack of reflection are issues there
for your Honour. It's not within the scope of this inquest to conduct a more
40 detailed review of Dr Boros-Lavack's practice, or whether or not these issues
are more widespread, but the regulator has the opportunity and that may give
your Honour some comfort that there won't be a repeat.

In relation to Dr Grundy, counsel assisting says that your Honour could
45 embrace the submissions made on his behalf. Your Honour would find the
submissions of Ms Mathur SC persuasive at paras 12 to 23. Although it's true
that Dr Grundy could have been more proactive in chasing up that letter and
it's regrettable that he wasn't, he was not given the information that would
necessarily prompt a review, in a way that you could be critical for him not
50 doing it. It's regrettable that he didn't recall Joel given that he'd been a patient

for a long time, but there was nothing in that letter to note that it was a recent decline in way that would've mandated a recall.

5 In relation to Drs Ruge, Parkar and Barkla, in our respectful submission your Honour would accept the submissions made on their behalf by Ms Mathur SC. In relation to Dr Pietsch, your Honour would not accept that Dr Boros-Lavack called him on the telephone. Perhaps she genuinely believes now that she did, but this appears to be a reconstruction. There's no primary evidence of a call between Dr Pietsch's practice and the Mi-Mind centre on the day of the
10 appointment, that is 13 November. There is only primary evidence of a call on 16 November 2023 from Mi-Mind to Dr Pietsch, and it's not clear that Dr Boros-Lavack made that call as opposed to the practice.

15 Dr Boros-Lavack gave evidence multiple times that Dr Pietsch called her, and that does not align with the phone records. Further Dr Pietsch gave persuasive oral evidence that "Given I wrote Dr Boros-Lavack a letter on 13 November 2023, it doesn't make sense that I would've written that letter after just calling and speaking with her on the phone and not referring to it." It's regrettable that so much time has had to be spent on whether the evidence
20 of Dr Boros-Lavack should be accepted. Even the most competent practitioners make mistakes, and it is accepted that psychiatrists make difficult decisions each day about which reasonable minds can differ.

25 The problem here was the combative nature of Dr Boros-Lavack and the failure to accept responsibilities for the deficiencies, albeit the belated acceptance of the handover deficiencies. I can just end on this note. A snapshot of what happened to Joel exposes some of the bigger issues and challenges for psychiatrists and general practitioners who are managing patients currently in the system as it is with chronic treatment resistant
30 schizophrenia. I've referred to the eminent panel of psychiatrists, but of course we also had an eminent panel of general practitioners, two practitioners Dr Hester Wilson and Dr Kruys who also commented on the challenges for general practitioners when they manage patients.

35 To that end, we have recommendations 1 and 2 which go to the need for a guideline on managing patients with schizophrenia, treatment resistant schizophrenia in particular, and managing patients on clozapine. The recommendation is addressed to the Royal Australian and New Zealand College of Psychiatrists. Again, difficult to read, and it'll be available for
40 review. It has been developed with the great assistance of the psychiatric and general practitioner panel. Your Honour shouldn't think that counsel assisting has made that up. We've had the enormous benefit, ongoing over the last couple of months, of those extremely experienced psychiatrists and general practitioners who work on the ground as consultant psychiatrists and general
45 practitioners, as well as having an academic role. They urge their college to embrace the need for a guideline in this area.

50 I can end there and break for morning tea, and I'll resume very quickly with the response of Queensland Police when we come back and then cover Scentre and NSW Ambulance. Can I just say this? I have had to spend some time,

LTS:DAT

5 given the level of conflict in reply on Dr Boros-Lavack, but there is much more
in our vast written submissions about the need for broader reform, and it was
strongly felt by the panel of psychiatrists and general practitioners that there is
a need for focus on those broader issues, rather than trying to drill down just
on mistakes that may've been made by an individual. I commend those
broader reforms for consideration to your Honour, and we are very grateful, I
know the Court is, for the help of NSW Health who has really embraced this
opportunity to look at this tragedy and see whether or not there are bold
reforms that will save lives in the future.

10 HER HONOUR: Yes, absolutely, thank you Dr Dwyer. We'll take the morning
adjournment and resume at 12.

SHORT ADJOURNMENT

15 HER HONOUR: I just resumed Court. I'll just ask those online to go on mute,
please?

20 DWYER: I come now to Part 3 as I identified it for oral submissions, noting of
course that there is far more detail in relation to these topics and more in our
written submissions. Can I cover briefly the response of Queensland Police to
issues that emerged with Joel Cauchi that they became aware of? Given the
level of agreement between parties and the very genuine reflections and
insight demonstrated by the Queensland Police Force as a service, and the
individual officers involved, these submissions can be dealt with very briefly.

25 Although Queensland Police interacted with Joel Cauchi a number of times
between 2021 and 2023, and they are each set out in detail in counsel
assisting written submissions, the one that created the best opportunity for an
intervention into the mental health service was 8 January 2023. Although
30 police also had limited information at that time, as I'll come to. On that date,
as your Honour will recall, Mr Cauchi contacted the Queensland Police Service
wanting to report his father for stealing his knives.

35 Mr Cauchi was living at his parents' home at the time, and of course it
emerged that Andrew Cauchi had taken those very dangerous knives from
Joel because he was worried about him having access to them. Senior
Constables Matthew McDonnell and Hope Porter attended the family home
and they spoke with Joel Cauchi and his parents. They recognised that Joel
40 appeared to be fixated on the knives, but he described them as "military
collectors items" and he was fixated on them needing to be returned to him.
He still wanted his father charged for theft.

45 The interactions between the officers and Joel Cauchi, as well as between the
officers themselves and then Mr Cauchi's parents, were captured on the
body-worn video which is very helpful for the Court to understand what
happened. The event was recorded as a domestic violence incident by the
police officers. However, both officers considered a domestic violence
application and order would not be appropriate. I pause to note that both of
50 the officers would have impressed your Honour as genuinely empathetic to

both the parents and to Joel when they attended.

5 Both officers did not consider that Mr Cauchi met the threshold to detain and transport him to hospital for an assessment. That is, they did not consider that they had the power for an emergency examination authority under s 157B of the Public Health Act in Queensland, which assumes some importance during the course of the inquest. It is possible that another officer in those circumstances, perhaps somebody more experienced with mental health issues, might have persuaded Joel to come in for a review, or might have found a way to justify a detention. Your Honour will recall the evidence of the very experienced MHIC Sergeant Tracy Morris who says that she might've thought that he could be detained or that she would persuade him.

15 But I submit your Honour would not be critical of the officers in attendance on that day. There is a problem with the legislation which is widely recognised in terms of how limited it is in giving powers to the police in those circumstances, and it suggests the need for legislative reform to empower officers in Queensland. Can I commend to your Honour the very careful and very helpful submissions that have been done on behalf of the Queensland Police Force. I don't have time to cover them in detail, and I note Dr Freckelton SC might refer your Honour to these in more detail in his submissions.

25 But they very carefully set out the power of Queensland police officers to detain a person under that Act, and in brief s 157 of the Public Health Act states that an ambulance officer or police officer may detain and transport a person to hospital if the person's behaviour indicates that they - that person - are at immediate risk of serious harm and the risk to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication or another reason and it appears to require urgent examination, or treatment and care, for the disturbance. It's very narrow, in that it focusses on the person rather than a broader concern for anybody else there.

35 The example given as to whether or not a person is at immediate risk of serious harm is the person threatening to commit suicide. Those powers are sufficient if the police are asked to attend to somebody who appears to be suicidal or exhibiting self-harm ideation, but not if somebody demonstrates obvious psychosis or potential psychosis as in this circumstance, or paranoid ideation. It just simply does not equip them. In the submissions on behalf of Queensland Police, they carefully set out why there is a need for an amendment of that legislation. They set out the helpful evidence that was given by senior members of the police force, including Acting Deputy Commissioner Kelly.

45 They also point to the evidence given by the expert panel on the need for or the benefit of expanding the powers under that legislation. As a result of that, counsel assisting has proposed a recommendation. It's recommendation 3. It might pop up on the screen now, directed to Queensland Health. That Queensland Health consider an amendment to s 157B of the Public Health Act in line with the comments in counsel assisting's written submissions. I note

that Queensland Health has not wished to be heard either in favour or against that, but that is a submission that was embraced by the individual officers. Not just one individual or more junior officers on the ground, individual more senior officers who deal with this regularly, including Sergeant Tracy Morris and very senior members of the Queensland police force.

The officers who attended on 8 January did the right thing in referring this incident to the local MHIC. They did think that Joel was experiencing some mental health concerns, but they didn't think that they had the power under that limited section to refer him or detain him to take him to hospital. On 8 January 2023, Senior Constable McDonnell sent an email addressed to Senior Constable Peter McDiarmid who was relieving in the role of mental health intervention coordinator in the Darling Downs Police District, requesting that follow-up be made with the family and Toowoomba Mental Health, noting the decline in Joel's mental health and the information that police were given by his mother Michele.

Acting Sergeant McDiarmid reviewed emails from the weekend and saw this email, but given the volume of other matters he had to deal with, he inadvertently overlooked making contact as requested by the email. Senior Constable McDiarmid was relieving in that role for a period of weeks, and it's clear he had a huge workload. There was no system of reminder in place at the time for matters that were missed. He acknowledged that it's regrettable that he didn't follow it up and he should've done, but he neglected to do so in the context of a system where he was not receiving adequate support with resourcing.

On 22 January 2023, Sergeant Morris returned from leave. She was extremely experienced in that role. She didn't take any action regarding 8 January email in relation to Joel because it had also been sent to the officer acting in her position at the time, Officer McDiarmid, and it wasn't referenced in the handover email she received when she came back from leave, and she assumed that matter had been addressed. It's a terrible confluence of events that she was on leave at that time. She gave evidence about what she would've done to follow that up, and she would have been concerned by what she was hearing. The counsel for the individual officers, Mr Gnech, and Queensland Police officers who gave evidence conceded that human error, but they also draw your Honour's attention to the limited resources in an imperfect system which has coped with a massive increase in the number of mental health call outs.

The evidence is, your Honour, that Senior Constable McDiarmid is a competent and dedicated officer. He was one of the only staff members willing to take on that role when Sergeant Tracy Morris was on leave, and your Honour heard if he hadn't have done so, it might have gone unstaffed, as it did for the period when Sergeant Morris was giving evidence in this Court. So in my respectful submission - in our respectful submission - no adverse comments should be made about the actions of individual officers, but they are to be commended for the frank, open, helpful way in which they engaged in the evidence in this inquest and assisted your Honour in dealing with the systems

issues and really embracing the opportunity for change that will empower them to help members of the community going forward.

5 Your Honour will no doubt outline in your findings I imagine the cracks in the system that all relevant parties are agreed on, as well as the action that has been taken by Queensland Police since and what still needs to be done. In the submissions of Queensland Police, they point out the action that's been taken. Your Honour, they commence by noting that police have an increasing role to play in dealing with persons who are mentally ill or mentally disturbed. 10 And I alluded to this at the beginning of submissions. The numbers are extraordinary. As pointed out in those submissions at para 8, it was reiterated through Inspector Quinlan's evidence that in Queensland, mental health calls for service by police increased by 51.3% between 2016 and 2020, with no corresponding increase to resources for police to enable them to deal with that increase. 15

So, I'll start that again. In Queensland, mental health calls for service increased by 51.3% between 2016 and 2020, with no corresponding increase in resources for police to enable them to deal with that increase. And there are 20 similarly alarming figures in New South Wales, very similar.

In April 2024, NSW Police released their summary internal review of the NSW Police Force response to mental health, which examines the demand on NSW Police Force in responding to the mental health incidents in the 25 community. Your Honour will recall this evidence; on average a mental health incident is attended and recorded by NSW Police every nine minutes. In 2022, NSW Police recorded 61,164 incidents in the COPS system in relation to people experiencing a mental health emergency or incident where there was not an associated criminal offence. So that's not even including all the various incidents they get called to when an offence has been committed by someone 30 suffering a mental health incident. That represents an increase from around 43,000 incidents in 2018. It's a 41.6% increase between 2018 and 2022.

In Queensland, a 51.3% increase between 2016 and 2020. In 35 New South Wales, figures show a 41.6% increase between 2018 and 2022. As Dr Nielssen said, the reasons for that are complex, but it is clear that it has been a huge burden on New South Wales and Queensland police to try and deal with this in a way that keeps patients and community members safe. Both New South Wales and Queensland are working with co-responder models to 40 try and ensure the right expertise and resources are available, but in both States, greater resources are required. And that was acknowledged very frankly by both service providers.

The Queensland Police Force submissions provide that the police have 45 worked to establish structured services and programs to support and train frontline officers responding to mental health call outs. But even with the most excellent training and equipment, it is not the core business of police, or if it's part of their core business now, it is not what has been the core business previously, and they do not profess to be the experts in the area and want 50 co-responder models that will provide them with expertise in the field and help

to relieve the burden.

5 In Queensland, the mental health intervention coordinators appear to play
a central role in coordinating a response, and that system appears to be a very
good one. It just needs more resourcing. Since giving evidence on 23 June
2025, Acting Deputy Commissioner Kelly wrote to all the Queensland Police
Service regional assistant commissioners seeking their assistance to extend
10 MHIC positions throughout the State. A copy of that letter under the director's
hand was provided to your Honour. As a consequence, there are eight new
sergeant MHIC positions that have been approved and are in the process of
being created. The eight new positions are in addition to the preexisting six
positions.

15 Your Honour, I pause to note what I said from the outset, that that's an
example of what can be achieved during an inquest with the goodwill and hard
work of parties. It's sometimes what goes unnoticed, because your Honour
then doesn't have to make a recommendation in relation to the increase in
those officers necessarily, because the hard work has already been done.

20 There is, however, as I anticipate, further resourcing required by both
New South Wales and Queensland police, and so that is why it was the subject
of a recommendation. The recommendations are worded in a way that gives
flexibility to Queensland Police and NSW Police to continue to design and
resource services and systems that will be best for those States, but they
25 nevertheless hopefully bolster the very significant efforts of senior
management in Queensland and New South Wales police to get their officers
and our communities the help that they need.

30 I'm moving quite quickly, your Honour, because I'm going to run out of time.
So might I move then onto part four, which is the security response. The
majority of the issues addressed in counsel assisting's written submissions
concerning the security response, which is in effect the preparedness for and
response on the part of Scentre, Glad and Falcon on 13 April 2024, are not in
dispute. They are agreed.

35 As a reminder to those in Court and observing, during the hearings earlier this
year various non-publication orders were made, and pseudonyms were used
for a number of security staff who were directly involved in the events of
13 April 2024. So in these oral submissions I propose to name that person
40 once and then the pseudonym. The reason for naming them is really just
because otherwise it's very difficult to follow these oral submissions. But
I observe the importance of the non-publication orders.

45 In short, and as set out in detail in our submissions, first, Scentre's policies and
procedures for responding to an active, armed offender, including the red
book, in our submissions represented best practice. Second, both Scentre and
Glad required security personnel to undergo significant training prior to and
during their deployment in Scentre premises. And third, the deficiencies in the
response as it played out on 13 April 2024 were largely agreed on, and they're
50 addressed in detail in counsel assisting's submissions at para 1552.

5 That includes, among other matters, the CCTV control room needs to be
manned at all times, and it wasn't on 13 April at the relevant time. There were
failings with the contents of the initial alert from GLA2. She's referred to as
GLA2 in these submissions, and a reminder about the non-publication order
over her name. The failings in the contents of that initial alert, which are very
human errors, nevertheless led to a slower response. And the CMEO/EWIS,
that is the warning system, should have been activated sooner.

10 There are however discrete topics emerging from the written submissions that
need to be addressed by way of closing submissions where there is room for
difference of opinion. That includes these seven. The criticism of Mr Wilson,
the security expert. Second, the training provided to CR1, who's referred to as
15 CR1. That's the first and only time I'll use her name. The non-publication
order is over her name. CR1 in the CCTV control room. Third the overall
response by Scentre on 13 April 2024. There are some small points of
difference. Fourth, the particular response on the part of CR1 on that day.
Fifth, Pikria Darchia's response to the attacks and the significance of her
20 movements. Next, the contents of the first radio alert. And seventh, the
recommendations that are proposed in relation to this security topic. I'll deal
with each of those in turn.

25 Firstly, in relation to the criticism of Mr Wilson as an expert, who was retained
by counsel assisting. The two-pronged attack on Mr Wilson by both Scentre
and Glad was not warranted, in our respectful submission, and it does those
parties no credit. Scentre contends that Mr Wilson's opinions were affected by
inaccuracies, poorly founded assumptions, or that they're inappropriately
general or widely cast propositions. That's the submissions of Scentre at
30 para 205.

35 Scentre further submits that Wilson's "evidence on any topic concerning the
security response should be scrutinised carefully before it's accepted". That's
at para 220. Glad endorses the position adopted by Scentre, but also agitates
its own separate complaint, namely at para 40 of their submissions; that little
weight should be given to Mr Wilson's opinions in circumstances where he
lacks specific expertise in overseeing security operations in large shopping
centres. Glad ultimately submits that the divergence of any opinions between
Mr Wilson and Mr Yates is readily resolved by accepting Mr Yates' evidence,
40 as he is of the two more experienced in the relevant field.

45 Where it lands, your Honour, is that Scentre and Glad are more than happy to
accept positive opinions of them rendered by Mr Wilson, such as in respect of
the red book, the quality of the services agreement between Scentre and Glad,
and the training programs provided by Scentre and Glad. But when it comes
to criticism, they take umbrage and say that his opinions cannot be sensibly
accepted or that he doesn't have the requisite expertise to express such views.

50 In our submission, Mr Wilson was eminently qualified to give the evidence that
he did. These matters are addressed in detail in our submissions at
para 1,007. His CV is objectively impressive, including amongst other

evidence, the evidence he gave as an expert on the Manchester Arena bombing and Christchurch terrorism attack. He also has extensive private sector experience, including in respect of retailers and operators of crowded places.

5

Insofar as the criticism is directed at Mr Wilson's opinions more directly, again that submission falls short. Mr Wilson repeatedly accepted and made concessions in relation to his expert report. He acknowledged them in his supplementary report, particularly where he'd made errors such as with the timing of the initial triple-0 call. Mr Wilson was briefed late last year. He worked through a huge volume of material in a short period, and he has provided very valuable assistance to this Court. There's no reason why his opinion should not be accepted.

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Insofar as Mr Yates is sought to be qualified as an expert, we deal with this in submissions at 1,009. Mr Yates does have very significant expertise and experience, but nothing, in counsel assisting's submissions, should be taken as to elevating him to the role of an independent expert. He gave evidence as a partial witness. That's not a criticism of him, but by definition he's conflicted because he's a paid representative of Scentre and an advocate for their interests. Again, we're not saying that as part of any criticism of him. The suggestion that his evidence is to be preferred to that of an independent expert can't seriously be made in those circumstances.

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I come then to the training of CR1. Counsel assisting's submissions at para 1,370 are in these terms. The evidence regarding CR1's training, and in particular the completion of the CCTV training checklist, including why it was all signed off on the same day, as well as the content of the further reviews undertaken by Mr Zaidi and Mr Goldberg is unsatisfactory and remains opaque. Scentre objects to that characterisation at para 151. With respect, counsel assisting maintains that submission.

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First, there was no proper explanation as to why the CCTV checklist was signed off on the same day by Ms Fatima and Mr David. Mr Goldberg offered the further perspective that they had lost the original checklist, but what really happened was not resolved.

40

Second, there's a lack of clarity as to who did sign offs from Scentre's perspective and when these occurred. Despite the valiant efforts by Scentre to recast Mr Goldberg's frank evidence at para 141 to 151, nothing in Scentre's submissions make the situation any less opaque.

45

Third, Mr Goldberg referred to having conducted his sign-off of CR1 by reference to a checklist, which he completed, and which he accepted was not in evidence and that he doesn't know where that document is. We've given the transcript references. It's again another mystery in respect of the sign-off process that hasn't been answered, and it raised more concerns about the entire training procedure. I just interrupt myself to say, there's no intention to be critical of Mr Goldberg, he was doing his best to assist the Court, but the evidence remains in a state that is unsatisfactory.

50

In the final analysis as it was set out in counsel assisting's submissions, despite the identified issues in respect of CR1's training, it was her performance on the day that was the real issue. Counsel assisting's submissions at para 1374 and 1377 are in terms that note this:

5

"Ultimately CR1 was not sufficiently equipped with the skills to do what was required of her on 13 April 2024. Unfortunately the events of 13 April came too soon for anything to have been done to address those issues in a meaningful manner, and the issues identified her communication skills, the deficiencies in her ability to operate the CCTV system and her issues with escalating matters were exactly the skills that are required of a CCTV operator, facing an active armed offender scenario".

10

15

There were numerous issues identified by those training her in respect of CR1's competencies leading up to 13 April, and they're recorded in the weekly operational minutes. They included that she was too slow as at 10 April, and that it would be difficult to accept any alternative submission that CR1 was competent to work in the control room, unsupervised, as at 13 April, because of the issues that had been identified in the weekly operational minutes.

20

Scentre again objects to that submission. They say that the submission fails to grapple with the evidence of Ms Fatima, Mr Goldberg, Mr Helg, Mr David, Mr Stuart, all of whom considered CR1 to be competent to perform the role of the CCTV operator.

25

Scentre says this at para 172:

30

"With respect, the submission by counsel assisting that, given the weekly operational minutes it would be difficult to accept any alternative submission that CR1 was competent to work in the CCTV control room unsupervised, fails to grapple with the substantial body of first-hand evidence outlined above. Counsel assisting does not explain why the evidence of primarily Ms Fatima, but also broadly consistent evidence of Mr Goldberg and Mr Helg, Mr David and Cameron Stuart, would be entirely rejected to make instead the adverse findings based on the weekly operational minutes that are proposed by counsel assisting in 1374 and 1377".

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Your Honour counsel assisting maintains the submissions made in our original written submissions. We say that the position advocated for by Scentre is with respect misguided. Properly considered there is a body of evidence upon which a finding that CR1 was not competent to work in the CCTV room unsupervised as at 13 April 2024, can be made. We're not suggesting that she couldn't do a substantial part of the role, but she was not well-equipped to respond in these circumstances.

45

An important caveat on the witness evidence that Scentre relies on to demonstrate CR1's competency is that they are all people who were directly

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involved in the sign-off and training of her. So understandably and without criticism of them, their opinions may be influenced by that involvement, even if subconsciously. Further, it ignores the fact that Mr Goldberg accepted with the benefit of hindsight that CR1 should not have been left in the control room unsupervised on 13 April 2024. His reflections and insight and the calm manner in which he gave that evidence reflectively, was appreciated.

The attempt in the submissions of Scentre at 265 and 271 to re-cast what Mr Goldberg said, stands in the face of his very frank and helpful evidence. He said this, the question was:

"I'm going to ask you again for your reflections. I started to read to you something that Mr Wilson says in his report, and just in summary what he says is that 'Although these issues were being raised, it should've been the case that CR1 was not left alone in the control room due to these identified needs'. When you reflect on it, given how incredibly important that role is in the event of an emergency, like an active armed offender, is it the case that your reflection is she shouldn't have been left on her own".

And he said, "I suppose no-one expected a situation of this gravity to occur and in hindsight I would agree with that". The two passages Scentre point to, at paras 268 and 269, are further concessions that CR1 should not have been left unsupervised on that day. The best record of her competency comes from contemporaneous documents available before the Court, and that's accepted by Scentre.

Scentre say this at para 123:

"However some of that evidence as to sequencing relied upon memory rather than contemporaneous records, which despite honest attempts at recollection, had understandably been affected by the effluxion of time and events".

Your Honour the weekly operational minutes demonstrate that CR1 was struggling in the role and not competent for it in the months leading up to 13 April. In brief, these are set out in detail of course; the WOM, or weekly operational minutes, provide 13 March 2024:

"She needs updated training". Same day, "She needs further training, doesn't follow-up with further details, constantly asked to repeat, labelling photos correctly". 24 March "Still ongoing issues with CR1". 27 March "Ongoing issues with CR1, re-schedule full control room training again with CR1". 10 April "Reports not being done on nightshift and pushing for dayshift. Responses from CR1 too slow" - this is three days before the events - "Re-training to be scheduled for CR1".

So when read together they clearly show someone facing real difficulties who required full control room training two weeks before the incident, and

re-training in the days before. They point in one direction, that she shouldn't have been left on her own on 13 April, and that was a matter known to both Scentre and Glad.

5 I just pause to note this, that it's recognised that it must be very difficult for
CR1 to then, even though she didn't give evidence, to follow the evidence as
she may be doing; it's not suggested that it's an attack on her personally or
that she wasn't competent in a whole lot of areas, the point is she wasn't
competent to respond on 13 April, and that was known to Scentre and Glad.
10 That doesn't mean she shouldn't have held a role, but she shouldn't have been
left in that control room on her own, however rare an active armed offender
event is, or an emergency of this nature, there must be somebody competent
to respond to it in that role.

15 Counsel assisting's submissions address that there was a delay from the time
of the initial notification by GLA2 at 3:33:33 until the time when the active
armed offender incident was verified by Mr Zaidi at 3:36:36. At which time the
active armed offender red book procedures began to be implemented. Scentre
seeks to avoid the force of that criticism by identifying and contextualising what
20 occurred in the period from the first alert, to the verification, in which staff are
said to have responded in accordance with the generic responses provided for
in the red book.

Scentre further submits at para 231 that the insufficiency of information
25 provided by GLA2 did not delay actioning the emergency response procedures
under the red book, because the generic guidelines were enacted immediately
in accordance with the structure of the red book. What we say your Honour is
that while generic procedures might have been implemented, there was clearly
a real delay in the specific active armed offender response being implemented.
30 It's not to suggest that that's not difficult or demanding; the problem is that an
active armed offender is a hugely particular incident which occurs at great
rapidity across a large area, and it's unpredictable. It's necessary to default to
the specific emergency response as soon as possible to save lives.

35 The generic response in the red book provide that security staff are to one,
conduct an initial assessment of the condition and situation, two, contact
emergency responders via triple-0, and three, identify hazards that could
cause more casualties and if the area is not safe, move people away from the
dangers and warn others against entering the danger area. So that response
40 could clearly apply to a number of different situations, theft, fire et cetera, they
are by definition general or generic.

The red book AAO procedures are of a different character and they stress the
urgency of disseminating information of the threat posed by an active armed
45 offender. They are one, get people to safety, two, get information to police,
three, notify people through a public address, the CMEO et cetera. Information
and awareness are all critical aspects of responding to an AAO, so bystanders
can then enact the escape, hide, tell protocol and get themselves out of harm's
way.

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5 More critically, Scentre's position ignores a fundamental problem, that there should not have been a need for verification of that report by any member of the Scentre team. The alert came directly from a security guard who had personally witnesses the relevant event. Scentre's submissions at para 68 address as much; they say "If a trained security guard sees an active armed offender, the guard can both identify and verify an AAO event in one radio call". If GLA2, a trained security guard, had radioed at 3:33:33 that she had seen an active armed offender, that would be verification enough to activate the AAO guideline.

10 As Mr John Yates said, "A call by a security guard of code black alpha, 'Code black alpha, I've seen a man stab somebody' with a description, would be verification". But none of that occurred on 13 April. That necessarily compromised the response from other security responders who exposed themselves to potential danger in a pursuit of verifying what happened, and it resulted in a delayed response when there was a critical need for the active armed offender procedures to be implemented as soon as possible.

15 I come next to CR1's response on 13 April. At para 261 Scentre makes the somewhat surprising submission that Mr Wilson's evidence that CR1 was not competent on 13 April, should not be accepted. This adverse conclusion is contradicted by what the objective evidence of the CCTV demonstrates, especially when reconciled with radio broadcasts apparently being made by security officers and centre staff within Scentre. She did step up under the pressure. Contentions to the contrary have not properly engaged in a balanced or sufficient analysis of the objective evidence adduced in the inquest.

20 Counsel assisting does not accept that your Honour. This submission is made on the assumption that CR1 was in fact doing various matters after she returned to the CCTV control room following GLA2's alert at 3:33:33. At para 240 of their submissions, Scentre provides a suggested account of what CR1 did after the alert from GLA2. This account is in effect based on opinions or submissions following reviews of the CCTV footage by persons unknown. There are also many instances where Scentre seeks to portray what occurred in an unduly positive light, with respect. For example, at para 259, there's a suggestion that CR1 called triple-0 of her own initiative. This ignores the chronology, that is that Mr Zaidi had made a call for blue lights at 3:35:30, with the first attempt by CR1 at contacting triple-0 occurring after that call, approximately 30 seconds later.

30 Putting these matters to one side, the fact remains that what actually occurred on 13 April 2024, after the first attack, demonstrates a lack of sufficient competence on the part of CR1 to respond to an active armed offender in that particular scenario. That statement is not intended to be unduly harsh. It doesn't mean that CR1 is a person who is incompetent more generally, not at all, but it means that she wasn't sufficiently trained and equipped with the appropriate skills at the time for what the role required in the extraordinary event of an AAO.

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5 However unlikely an AAO is in this country, it's a scenario that is contemplated and that CROs must be trained to deal with. Without addressing all the matters in the interests of time, the evidence demonstrates first, that Mr Zaidi had sent CR2 to the control room, despite being aware that there was already a controller in the CCTV control room, and he said he did that because he was confident in CR2's ability to respond to an emergency, with the chief warden's direction. That's counsel assisting's submissions at 1142.

10 Second, Mr Zaidi was unable to contact the control room after the alert from GLA2. He said:

15 "I continued to try to call the control room again to understand what was happening. I tried to radio the control room a number of times during the incident, although I cannot now say how many times. I would have been asking for the control room to review the CCTV. I do not recall receiving a response from the control room at that stage."

20 Third, likewise, Mr Helg attempted to contact the CCTV control room and received no response. Fourth, CR1 was unable to locate Mr Cauchi and was not aware that he'd been shot when she spoke to triple-0 at 3.42pm. That was nearly four minutes after Joel was shot. Fifth, Mr Gaerlan was frustrated with the information CR1 provided upon his attendance at the CCTV control room. He said:

25 "I remember being immensely frustrated. My key focus was to understand what was happening. I hadn't known any information other than the last call as I mentioned that Rahim had called through, and it was frustrating for me, because without that information I wouldn't be able to continue to do what's expected of myself."

35 Six, CR1's response was in stark contrast to how CR2 dealt with the situation. He immediately took control and without around 90 seconds of entering the CCTV control room he was able to locate Mr Cauchi on the CCTV. Finally, as I have already alluded to, Mr Goldberg accepted that CR1 should not have been left in the room alone. The evidence of Mr Wilson should be preferred. It can't sensibly be accepted that CR1 was confident to be left alone or that she stood up under pressure.

40 Glad at para 31 contends that the evidence of Lulu Fatima regarding her assessment that CR1 was competent to be a control room operator on her own should be accepted without reservation. We disagree. It can be accepted that Lulu Fatima was experienced and that she gave candid and impressive evidence. However, she was simply wrong in her assessment of CR1's performance. Further, Glad contends that Ms Fatima alone was the best-placed person to make a reliable assessment of CR1's competency. We disagree with that too. Clearly, there were concerns that had been raised in the weekly operational minutes by persons qualified to raise them and the records speaks for itself.

5 Finally, as the Glad submissions state, Ms Fatima had a central role in CR1's training and supervision between December 2023 and April 2024. In those circumstances, there is necessarily a question about the objectivity of her evidence, and that's particularly so when assessed against the contemporaneous records that raised concerns about CR1's performance, including April 2024. That's not intended to be a criticism of the competency or honesty of Ms Fatima.

10 Just one further issue needs to be raised in respect of CR1. The Court had great sympathy for the challenging position that CR1 was in on 13 April and the trauma she and other security staff experienced after these tragic events. By the time of the inquest, your Honour had received medical material from CR1 amongst others that outlined the mental health impact of the events of
15 13 April.

Whether to release a witness from a summons in those circumstances is a matter of discretion for the coroner taking into account considerations like first, how significant a witness they are; second, just how unwell the witness is
20 stated to be; third, whether alternative arrangements can be made in court to make it easier for them to give evidence and protect their health; fourth, whether written statements and supplementary statements could be prepared to address the evidence; fifth, the attitude of other parties to the bar table and whether it's important to them including families of course, very importantly, to
25 hear from a particular witness when they want answers into what happened to their loved ones.

In this case, there were matters that pointed in favour of CR1 giving oral evidence and there was discussion about whether or not arrangements could
30 be made. They included that she's a very important witness, that some of the parties were very interested in being able to cross-examine her, and there was a prospect of course of making adjustments in court that might have made it easier for her, for example, counsel assisting deals with most of the
35 examination.

But on the other hand, against that, she did appear to have very legitimate health issues that justified excusing her, and crucially, she was prepared to assist the Court with a written statement and a supplementary statement to
40 address the issues that arose, and that was appreciated and also of benefit to her in the circumstances. The Court is mindful of a therapeutic approach wherever possible, including towards witnesses in these circumstances that have experienced trauma, and different coroners in different jurisdictions may take a different view. Reasonable minds would differ as to whether or not she should have been summonsed. But your Honour, in my respectful submission,
45 is extremely sympathetic and empathetic to her.

Glad submits at para 36 that the Court should "tread carefully before making any adverse findings against CR1 when she was not given an opportunity to respond to specific and serious allegations made against her". They say, "This
50 is not a criticism of counsel assisting but simply an observation of the

procedural difficulties involved when a witness is too unwell to give evidence".

5 Your Honour, to the extent that the submissions suggest that there would be a denial of procedural fairness to CR1 to make an observation that is critical of her actions, because the Court acceded to her request not to give oral evidence, the Court would reject that. CR1 did have an opportunity to give evidence orally or in writing. She asked to give evidence in writing rather than orally because of the circumstances I've set out, and therefore she wasn't subjected to cross-examination. She was represented by very experienced senior counsel and a legal team who could take instructions from her and who advocated on her behalf during and after the hearing.

10 It would make a mockery of an application to avoid giving evidence on health grounds if the corollary was then to silence proper analysis and critique, and that analysis and critique I'll just say for the final time is not intended to be a criticism of her personally or her competence more generally. But moreover, it warrants emphasis that counsel assisting's submissions are premised on the facts as known, including from contemporaneous records and CCTV footage. So it cannot properly be contended for that inferences drawn in relation to those facts can't be critical or adverse because a witness relevant to the factual matrix has not given evidence for health reasons, and that's particularly so when the witness is represented.

15 The factual analysis of what happened is done with a view to learning lessons that may save lives in the future. It's an essential part of this Court's statutory mandate and no doubt the Court is grateful for the assistance that CR1 was able to give in relation to her written submissions and supplementary submission which assist to understand.

20 I come to the next topic of Ms Darchia's response to the attacks. Scentre submissions included a particular focus on responding to the counsel assisting submission as to what may have occurred, had procedures been implemented sooner and an alert made at an earlier point in time, specifically in relation to Ms Pikria Darchia, who your Honour will recall was the last person to lose her life as a result of the actions of Mr Cauchi. Counsel submissions at para 1595 are these:

25 "There is at least the possibility that had alerts been deployed earlier, this may have resulted in a different outcome for one victim, Ms Darchia, as the last victim to have tragically passed from her wounds. Had an alarm been sounded at an earlier time, for instance shortly after an appropriate alert having been made by GLA2 at 3:33:33, Ms Darchia may have responded differently.

30 She may not have stopped to collect the items that she dropped and instead she may have attempted to hastily exit Westfield Bondi Junction or remove herself from danger. As it happened, 77 seconds elapsed between GLA2's initial alert and Ms Darchia being fatally stabbed."

35 40 45 50

5 Scentre seeks to blunt the force of that submission by relying upon a report prepared by Fulcrum which suggests that had the red book AAO procedures been followed from the very first alert by GLA2, it wouldn't have made any difference, as no alert would have occurred in time to warn her. There are a few things to say in respect of this. First, the Fulcrum report is a recreation, being a hypothetical exercise prepared in a vacuum, and which assumes that a policy would be followed to the letter. It can't be said with any confidence that if GLA2's alert contained sufficient information, that is, that there was a man with a knife killing people, that the CMEO or other alerts would not have occurred earlier.

10
15 Second, there's a question as to whether Mr White who prepared the report has appropriate expertise to opine on all the matters he does. From 2004, Grahame White was employed by Fulcrum. Since that time, his role has principally involved training. Insofar as his previous role before 2004 as a police officer gave him any special insight into how people respond to events including radio usage, that expertise is no longer current.

20 Third, the script prepared by Fulcrum is overly long. Mr White himself acknowledges as much at p 2. He says, "While it is acknowledged that the script could be made shorter and read faster, there is a point where the speed at which information is relayed becomes counterproductive".

25 Fourth, the script involves unnecessary steps. For example, the Fulcrum report at 73 provides:

30 "As such, within the script, I included the escalation of information from AA to the operator and then from the operator to the chief warden. I included the words, 'I am trying to confirm the report on CCTV now' to reflect that escalation process and attempts by the operator to confirm the initial report."

35 Mr Yates gave evidence that the report from the security guard would be verification, therefore, that step is not required. Further, Mr Yates gave evidence about the difficulties with locating people in real-time on the CCTV system which suggests a confirmation by the CCTV operator may lead to an even slower response.

40 Example number 2, the script then contemplates that the chief warden obtaining further verification from the CRO would have occurred at 3:34:12. It's unclear why this is required. There's no reason why the chief warden would not issue a direction to commence the PA announcements. That is, the CMEO at 3:34:12. That's still 40 seconds before Ms Darchia was attacked. The red book provides that the five main assignments including the CMEO and the public address are to be immediately enacted.

45
50 Example number 3, final example, the CRO providing a further confirmation at 3:34:33, over a minute after the first alert, is provided for in the Fulcrum report, and therefore the CMEO and PA announcements would only occur after 3:35:12. Where speed is crucial in responding to an active armed offender, in

our respectful submission, that script takes too leisurely an approach to the response.

5 Ultimately, the report is an opinion of what a response to the events on 13 April could look like. It doesn't change what's put in the submission made by
counsel assisting that had alerts been made earlier, Ms Darchia may have responded differently, and we don't put it higher than that. For all those reasons, the report should be put to one side. It would be wrong for the Court
10 to accept the opinions in that report as to the ideal counterfactual being representative of what would in fact occur.

Your Honour, there's footage that shows that around the time that Ms Singleton was attacked, Ms Darchia was in the area and she became
15 aware that something strange was happening that caused others to run. Ms Darchia can be seen in the footage initially running with the crowd. Later though, she stops and appears to assess the situation, before seeing the crowd run again. She dropped her water bottle and tragically she doubled back to collect it, and it's at that point that she is attacked by Mr Cauchi.

20 While Ms Darchia, an inference can be drawn, knew something was happening, there's no evidence that she knew that there was an active armed offender in that area or that others had been badly hurt. There were 77 seconds in which we say an alarm or an alert could have theoretically been issued and that may have caused Ms Darchia to act differently. In those
25 circumstances, counsel assisting maintains the submission at para 1597 that ultimately it's not possible to predict or prove the counterfactual for the potential for a different outcome to have ensued in the case of Ms Darchia cannot be excluded.

30 I'm coming to the end of the security section, your Honour, and might I comment on the contents of the first radio alert from GLA2 which is the subject of contention? An issue arises from the submissions of the parties as to whether or not it's appropriate for a finding to be made in respect of the contents of GLA2's radio alert at 3:33:33, which is the first notification of an
35 incident. Counsel assisting maintains our position expressed in the submissions at para 1567 that it's not possible or desirable to actually ascertain what was said. That witness was appropriately excused from giving evidence on medical grounds. Various other people who could give relevant evidence on the topic also did not give evidence.

40 The suggestion made on behalf of the Tahir family that any reasoning process done by the accumulation or aggregation of various accounts can't be adopted by the Court. The submission at para 63 that the radio message referred to blood and that there was a man with a knife stands in the face of objective
45 evidence. The fact that Mr Gaerlan and others went to the scene suggests that whatever was conveyed in the call was inadequate, as further information was required. That includes the location or the nature of the threat. It suggests ultimately that there was unlikely a reference to the knife, and this is dealt with in our submissions at para 1568. In any event, no finding needs to
50 be made as to the specific contents. It was self-evidently not sufficient

information that was conveyed from GLA2.

5 Another topic relates to the active armed offender messaging to the general public. Counsel assisting propose a recommendation at number 6. And that might come up on the screen. That's to the NSW Government to actively promote by way of an advertising campaign the principles of escape, hide, tell, including by encouraging operators and owners of crowded places to disseminate the messaging amongst staff, retailers and dealers.

10 Your Honour, there has been such a recent campaign from the Australia and New Zealand Counter Terrorism Committee. It was launched in October 2025 aimed at public safety with shopping centres and casinos to promote the safety message. Counsel assisting welcomes the campaign. Yet again it shows the benefits of inquests and that changes can be made during the currency of an
15 inquest that might make a real difference.

We still consider that there is utility in the recommendation being made, given how critical the situational awareness and awareness of the escape, hide, tell
20 message is. Mr Goldberg gave compelling evidence at the hearing to this effect. Situation awareness is important. It's key. If you watch some more of the footage, you'll actually see people are just walking around, looking on their phones while it's all happening around them, oblivious to what was going on. And it's actually one of the key lessons I taught my kids about situational
25 awareness when they're out; just don't be on your phones, just know what's happening around you, is definitely a key learning, he says.

In our respectful submission there's a real and ongoing need for emphasis of the publication of the escape, hide tell message to maximise its impact with the
30 general public, particularly in an era where phones are so distracting. And that's been recognised.

Other related matters on this topic, your Honour, just very briefly, counsel assisting's submissions refer to the volumes of the alarms on the day and the
35 adverse impact that had on first responders. There's extensive evidence of that, your Honour will recall. The alarms didn't go off until after Joel Cauchi was shot, the audible alarms, and they were so loud that it was distracting for first responders trying to communicate with each other.

40 Accordingly, a recommendation was proposed to Standards Australia, which urged them, having regard to the evidence of the volume of the alarms and the consequent impact on first responders, to undertake a review of the requirements of the relevant standards, including as to the standards that relate to the minimum volume of alarms. And there were further suggestions
45 that they should also look at colour coding.

Your Honour, since that evidence was given and Standards Australia were notified, counsel assisting were in contact with the relevant body, Standards
50 Australia, and Standards Australia responded. They were given relatively short notice, and the Court is very grateful for their assistance.

Standards Australia has advised that a technical committee was convened to give consideration to the relevant standard. So in effect, Standards Australia have already done what would have been asked of your Honour by way of a recommendation. Can I commend to your Honour the signed version of a statement from Ms Riley Takos of Standards Australia. She's Standards Australia's chief of engagement standards and international relations. I hand to your Honour a signed statement, two copies. That should go also, your Honour, in the brief of evidence at tab 1,699. In our respectful submission, there's no need now for the recommendation to be made to Standards Australia. I note that Ms Walz appears for Standards Australia, and Standards Australia have attended the Court.

You'll see from the volume of that statement that amount of work that has gone into that. The issue has now been raised with Standards Australia, so we feel that counsel assisting has acquitted the responsibility to raise that issue. But we acknowledge that what Standards Australia has to do is cater for a vast range of circumstances in which the alarms are used. So we don't press the recommendation to that, but we note that it will be no doubt be the subject of ongoing consideration in the way that it's set out in that statement.

Your Honour, I don't propose to deal with the issues in relation to the knife, because they are set out in some detail in our written submissions, and we commend those written submissions to your Honour.

Your Honour, I estimate another 15 minutes. Would your Honour like me to press on or to break? I'm grateful to Ms Mathur of senior counsel who has indicated in light of counsel assisting submissions that she will not require more than five minutes, so I have consumed most of Ms Mathur's time. I apologise. We did that in consultation with Ms Mathur.

HER HONOUR: I'm happy for you to keep going.

DWYER: Thank you, your Honour. Firstly, this is the last section, you might be relieved to know, that I need to deal with, and it relates to NSW Police Force and NSW Ambulance responding, and I'll touch briefly on the issues with respect to the media.

But can I start with the concluding remarks on this section that counsel assisting urge on your Honour, and that is that the Court would acknowledge the confronting and dramatic circumstances that faced all of the NSW Police officers and their NSW Ambulance counterparts when they volunteered their services on 13 April 2024. The Court would acknowledge and commend the professionalism and skill of all the NSW Police Force staff who responded, in particular noting the matters that we set out in written submissions. The Court would commend the efforts of Inspector Amy Scott, each of the NSW Police officers who responded to the incident on 13 April 2024 - that's at both a junior and a senior rank, including Chief Inspector Whalley - and the NSW Police Force radio call centre staff.

In addition to their work, your Honour would commend the bravery of the

5 civilians who accompanied police, including right up to the point where Mr Cauchi was shot. As a result of that, your Honour, is recommendation 8 directed to the council for Australian Bravery Decorations, given the exceptional bravery on the part of a number of individuals who confronted Joel Cauchi on that day. It's recommended that a number of persons will receive recognition, and that includes Inspector Amy Scott, Ashlee Good, Noel McLaughlin, Damien Guerot, and Silas Despreaux. None of them asked for recognition, but in our respectful submission that is entirely appropriate.

10 I hope I've adequately conveyed, but we do so in much more detail, the recognition that your Honour would give to the NSW Ambulance Service. It was pointed out repeatedly that in entering that scene, individuals did so thinking that they might come out, and they did so selflessly. And so we have said it in our written submissions that the Court would specifically commend
15 Inspector Simpson, who distinguished himself with decisive and lifesaving action in relation to entering what he thought was a hot zone with a view to saving as many victims as possible, each of the NSW Ambulance paramedics who responded to the incident. Inspectors Bibby, Saywell and Halcyon, each who demonstrated commendable leadership and initiative in assuming
20 command and control. They were later supported by their senior colleagues Armitage and Cronan, and the NSW control centre staff.

25 Again, while we're on this issue of the NSW Police Force, your Honour would acknowledge and commend no doubt the investigators from the NSW Police Force who were responsible for conducting the critical incident and coronial investigation in relation to these events under the auspices of Strike Force Mcauley. A number of officers were really severely affected by having to go through CCTV footage again and again and again and compile it to assist the Court, and we know that there's an accumulation of trauma that really has a
30 very significant impact on first responders, including assisting with these efforts. That relieved many of the lawyers from having to do that, but it also meant that families could really understand and grapple with what happened, as tragic as those events were.

35 Your Honour, in court today are members of the team who led that investigation: Detective Chief Inspector Andrew Marks, Detective Sergeant Paul Mangan, Detective Senior Constable James Bale. In our respectful submission, they have demonstrated the finest qualities of the NSW Police Force in their intellectual rigour and their compassion and empathy for the
40 families and their professionalism in assisting this Court. They were of course assisted by a number of others, and we specifically named them in our submissions.

45 Your Honour, the issues in this area are very limited because there has been widespread agreement, and they're addressed in detail in written submissions. There's complete agreement largely in relation to the key facts leading up to and concerning the response of the NSW Police Force and its officers to the events. That's in large part due to the collaborative engagement of
50 NSW Police Force and its legal representatives in relation to the chronologies that were presented before the Court.

5 The NSW Police Force also appears to accept the recommendations that are proposed to the extent that they effect the Commissioner's interest in terms of the emergency services interoperability. They are recommendations 13 to 15. They may or may not come up on screen, but they'll be available to parties and the media following.

10 Recommendation 13 to the Premier's Department, that is that the Department in consultation with the Commissioners of the Police Force, Ambulance and Fire and Rescue convene an urgent working group to develop and implement emergency services interoperability philosophy, model and framework for New South Wales. That sounds more complicated than we have tried to make it in written submissions, so we want these recommendations to be practical and able to be implemented, and we've set that out with some care in the written submissions.

20 Recommendation 14 to the Premier's Department is that there's consideration of the implementation of the ten second triage rapid screening tool by emergency services in New South Wales. Your Honour will recall the evidence called in this regard. It's a simple effective tool that's been trialled in other countries to great effect, and there was widespread acceptance of its benefits in saving lives in these circumstances.

25 Recommendation 15 to the NSW Police Force and Ambulance that there's a joint review of existing interagency radio communication protocols and processes in relation to major events. They were incredibly tested in these terrible circumstances, and it's an opportunity to learn and grow from going through this.

30 There are important recommendations which offer the potential for significant reform and structural reform in relation to emergency services interoperability. It's commendable, in our respectful submission, that the NSW Police Commissioner expresses his support for the recommendations.

35 Your Honour, in relation to the second topic, it's the nature and timing of the command briefing. The Commissioner's submissions from paras 26 to 35 reject the contention that the multiagency briefing at 5.30pm was effectively too slow. And that was a criticism advanced by Mr Wilson. It's not suggested of course that this had any impact on life saving in these circumstances, but we commend to your Honour the submissions of counsel assisting which cited his evidence at para 2,505.

45 Ultimately the significance of the issue relates directly to the emergency services interoperability and the need for early and frequent, what are called over the bonnet huddles between commanders. Both the Commissioner and NSW Ambulance accept that there are learnings in that respect, and the Court doesn't need to make any specific findings on the day on that issue of delay beyond noting that it underscores the importance for recommendation 13.

50 In relation to the hot zone issue, the Commissioner's submissions at paras 36

to 43 take issue with the contention that hot zone declaration at 4.28pm by Assistant Commissioner Armitage was properly characterised as a near miss and a significant error. The Commissioner certainly accepts that the hot zone issue represents an important opportunity for learning for ambulance and police, and that recognition is important. Counsel assisting adheres to the submissions on that issue, and we've set out the paragraph numbers. The descriptor of a near miss was accepted by the experts and also by Deputy Commissioner Wayne McKenna and Assistant Commissioner Peter McKenna in conclave.

The essential point is that it was very fortuitous in these circumstances. It was a violent fast-moving scene. It could not reliably be known whether all patients had been extricated at the point of the hot zone declaration at 4.28pm. That was necessarily so, given that there were other areas of that very large shopping centre which were yet to be swept by police. Whether or not Assistant Commissioner Armitage would have permitted paramedics to re-enter the centre based on up to date information is speculative, and it's somewhat beside the point, noting the delayed treatment in that instance.

But fundamentally, the point remains that it was a near miss from which learnings must be taken, and we're grateful to police and ambulance for embracing any opportunity for learning, as they have done throughout the course of the inquest. Counsel assisting reiterates the submission that was made as to the near miss.

So ultimately then it's not to be critical of individuals involved in that very difficult circumstance, but it highlights the importance of recommendations 13 to 15. We deal in our written submissions with the issue of the CCTV review. Assistant Commissioner McKenna ultimately accepted that there was an opportunity for police, at least through Sgt 2, to make inquiries and review the CCTV footage in Bondi Junction to establish the number of offenders at 4.07pm. Of course, by that period of time, Mr Cauchi had already been killed. But we maintain the submission, it's not a criticism of any individual officer, but there's an opportunity for learning in reflecting on that issue of CCTV review.

Your Honour, counsel assisting I don't think need to be heard in respect to other issues in relation to New South Wales Police but we commend to your Honour the detailed written submissions. New South Wales Ambulance provided submissions dated 22 October 2025 that accept the summary of the evidence and no factual issues arise. They embrace the recommendations proposed by counsel assisting directed to or affecting New South Wales Ambulance.

The Court is assisted by updated evidence from Deputy Commissioner Wayne McKenna in relation to what has already been done proactively by New South Wales Ambulance in reviewing any of the issues that relate to them. That means that one of the recommendations we made is no longer necessary. Could we just have recommendation 10(b) on screen? There are in fact two recommendations related to New South Wales Ambulance that are no longer required because of their proactivity.

10(b) was a recommendation to the Special Operations Team, otherwise known as the SOT, that New South Wales Ambulance give expedited and further consideration to a review and audit following recent steps to obtain new equipment to ensure the immediate availability of serviceable ballistics personal protection equipment for all SOT operators as required, with such equipment being readily available in close proximity to areas of deployment. Detective Commissioner McKenna confirms that the issues underlying that recommendation, in short, the lack of necessity PPE for all SOT operators, has been addressed. The Court would accept that evidence, grateful for that evidence, and that recommendation is no longer required.

Recommendation 11 to New South Wales Ambulance was that they review and revise a particular work instruction on clinical operations' response to active armed offender and public disorder incidents, and that they consider input from New South Wales Police as to the concept of zoning and the appropriate approach and terminology for scene management of an active armed offender.

The evidence of Detective Commissioner McKenna again is that that has been done and a revised work instruction has been issued. It was sent to staff on 11 August 2025. That's fast work by the New South Wales Ambulance. It reflects a respect for these proceedings and it's certainly of assistance to the Court and it means that that recommendation is no longer required.

Counsel assisting also accepts unreservedly that Deputy Commissioner McKenna's statement demonstrates ongoing work by New South Wales Ambulance on other proposed recommendations, some of which have been significantly progressed, and that's recommendation 9 in relation to the review of AMPLAN, which has included input from the subject matter experts in the UK; recommendation 10(a) regarding the review and establishment of the SOT; recommendation 12 in relation to the tranexamic acid in standard ambulance vehicles. It's another example of the value of inquests in getting work done throughout. That might be done by December.

Absent confirmation of the finalisation of those matters, counsel assisting maintains the recommendation are presently necessary or otherwise desirable, which is the language of the Act. However, as identified in New South Wales Ambulance submissions, in relation to recommendation 12, if for example there's evidence that tranexamic acid has been introduced to all New South Wales Ambulance vehicles prior to the inquest closing, we accept that the recommendation falls away and it may be that New South Wales Ambulance is able to alert your Honour to that prior to your Honour's findings.

So that leaves the final topic, your Honour, in relation to media reporting, and we can leave this to be addressed in more detail by the families, given it affected them so significantly. The submission on behalf of one family group, the Singletons, the Goods, and the Youngs, specifically concern the media. Your Honour heard that this was an issue that greatly affected them and no doubt other families.

5 In their submissions at para 5.44, they say that New South Wales Police haven't addressed these particular issues and the coroner should accept the evidence of Ms Singleton and Mr Wildley in relation to the unchallenged evidence that the police commissioner in effect informed the radio announcer Ray Hadley of Dawn's death. In our respectful submission, it's understanding why that would be upsetting to the family, very upsetting, but it's not an issue that was canvassed in the inquest. Your Honour, we respectfully submit that your Honour would be unable in those circumstances to make that finding, but we will leave New South Wales Police and families to address that in any further detail.

15 We do want to address an issue of great importance to the families more generally, and that's in relation to the general content and nature of the media response in relation to these events that were incredibly upsetting, that was very graphic, and that repeatedly showed images of Joel running around with a knife and in some circumstances showed very graphic images of people being injured. Counsel assisting submissions deal with this. It was issues 15 and 16 of the issues list. We rely on the matters set out in pt 11 of our written submissions. We commend to your Honour the submissions of the families about how distressing it was to them.

25 Counsel assisting recently corresponded with the Australian Press Council in relation to the proposed recommendations. We had regard to their correspondence in reply and have proposed a revised form of recommendation 18 in these terms to the Press Council, that they consider developing an advisory guideline to apply to the report of mass casualty incidents. That guideline should amongst other matters balance the need and desire for accurate, timely, and informative reporting of such incidents against the significant distress and grief that the reporting may have on victims, families of those who passed away, and members of the wider community who may be impacted by such incidents.

35 Your Honour will recall that in these circumstances there was inaccurate reporting initially of the alleged offender which caused great distress to family members and no doubt to that person, but also it's the graphic nature of what was reported. The recommendation therefore is in response to the compelling evidence from families in regard to the impact on them of media reporting.

40 Your Honour, might I interrupt myself to note that throughout the course of the inquest, there appeared to be from the media a real attempt to listen to the families and to what your Honour had said about that and the urging of counsel assisting, and so there was in my respectful submission what appeared to be genuinely sensitive efforts, and certainly on an occasion where there was graphic imagery posted apparently in error by somebody more junior from one media outlet, it was immediately taken down when the media were alerted. So these are issues that the media can respond to. It is possible to balance the public's desire to know with the need for sensitivity and discretion.

50 Of particular note, the Australian Press Council's letter of 31 October 2025 in

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response to the initial proposed recommendations said that the APC uses complaints data and stakeholder engagement to identify trends in the broader community concerning reporting on particular issues and then advisory guidelines are issued to supplement its statements of general principles.

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However, the evidence received during this inquest confirms the necessity for the APC to at least consider developing an advisory guideline concerning reporting on mass casualty incidents. The families impacted by the extreme trauma and distress of the events on 13 April should not have their terrible circumstances aggravated by insensitive, graphic, or inappropriate reporting, and responsible members of the media will no doubt agree.

10

In those circumstances, recommendation 18 is considered both necessary and desirable in the circumstances. In the UK, which has had to grapple with active armed offender incidents more than Australia has, there are such guidelines and it does appear to be having an impact on the media, so we commend that recommendation to your Honour.

15

Other matters are, your Honour, I should say addressed in very great detail. Finally, your Honour, I note that although I have raised necessarily in reply issues of contention, I should say, there was enormous cooperation from the parties at the bar table and there are very, very helpful written submissions from parties to assist your Honour in what is a very significant task in findings. But as counsel assisting, as a team, we're very grateful for the assistance that we've received.

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HER HONOUR: Thank you very much, Dr Dwyer, and of course I'm immensely grateful for the cooperation of all the interested parties and how you've approached this entire inquest but in particular the written submissions and the oral submissions today and Friday. We'll take the lunch adjournment now. If we resume at 2.15, will that give us sufficient time?

30

DWYER: Yes, thank you, your Honour.

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HER HONOUR: So 2.15.

LUNCHEON ADJOURNMENT

MATHUR: I've nothing to add other than to only embrace counsel assisting's embracement of our written submissions. In relation to recommendations, you'll note that at the end of the written submission we ask to reserve our position. Having seen the recommendations that pertain to the College of General Practitioners and the College of Psychiatrists, we don't wish to be heard and have nothing to add.

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HER HONOUR: Thank you very much, Ms Mathur. Mr Wilson?

WILSON: I'm content to rely on the written submissions dated 15 October 2025.

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HER HONOUR: Thanks, Mr Wilson. Dr Freckelton?

5 FRECKELTON: Thank you, your Honour. We have a few things we'd like to say. We'd like to start by expressing our condolences to the families of those who were killed in this tragic incident, and to echo what was said by counsel assisting in relation to the extraordinary courage of Inspector Amy Scott and all of those who assisted her both within the ambulance and NSW Police service and members of the general community. We start in relation to matters pertaining to mental illness in the community.

10 Dr Dwyer referred to the very large numbers of mental health calls to the service, to the Queensland Police Service and the New South Wales Police Force in recent years. They are substantial indeed. She suggested that dealing with mental illness isn't a core component of policing work. We
15 reluctantly would differ with her on that. It has become so by necessity because of a range of social factors, but the numbers of people who are in the general community who are unwell and drawing attention to themselves and posing a risk to themselves and to others, to identify some of the numbers there were over 50,000 mental health calls for service to the Queensland
20 Police Service in 2023/2024.

It's expected that that number will be a little bit more in the 24/25 year. A substantial number of those, unsurprisingly, relate to persons with frank mental illness. The numbers of those constituted something of a 50% rise
25 since 2018. That's a phenomenon that exists throughout Australia. It's more than that there are a great many calls, but they are complex and challenging for police officers, and they take a lot of time. The average time taken on mental health calls in 23/24 year for the Queensland Police Service was just over four and a half hours. Perhaps for self-evident reasons, they require
30 talking to the person at some length, evaluating their mental state, the risk that they might pose, talking to other relevant persons in the household, making decisions sometimes seeking advice, seeing how the matter is developing and then making a decision one way or another about what should be done.

35 The fact that there is such an increase in demand for such intervention is very significant Australia wide and does call for a rethinking of the role of police and of those who assist them in relation to persons who are symptomatic with mental illness. Mental illness overlaps with other areas as well, and we agree with what Dr Dwyer said in this regard, there's a substantial overlap with
40 homelessness, with domestic violence, with a range of other disabilities as well, including intellectual disability. What confronts police and other first responders is often a complex mix of presenting issues that need to be responded to in a sensitive and sophisticated way. This asks a lot of everyone involved, police included.

45 You have heard about the least restrictive principle and that emanates from the 1991 United Nations principles for the treatment of mental illness, and it's also found expression in the Convention on the Rights of Persons with Disabilities and in Queensland with the Human Rights legislation, and it's been built into
50 legislation through most parts of Australia. What that means is that first

responders are required to add to the amalgam of issues which they are processing, the need to intervene as little as possible in respect of people's rights to freedom of expression and movement and thinking and so on. There's a quite high bar set to when coercive action is legitimate and appropriate as a matter of law. That's all part of what needs to be balanced.

You might recall Inspector Quinlan talked about the difficult balances in this regard, and you've heard evidence about the deleterious consequences of the invocation of coercive powers by police. For instance, in relation to persons with mental illnesses. There's a risk that while that might propel them to be assessed by qualified mental health clinicians, that initial interaction with authority figures that takes the form of a measure of confrontation can be problematic in the development of therapeutic relationships by the clinicians, and it can give rise to a legacy of tension with police officers in the future, a disinclination of the part of persons who have had or do have mental health symptomatology to respond to attempts to be collaborative with persons when they encounter them in the street or as a result of having been called to answer issues.

Again, those are issues which need to be taken into account. The impost on time, the need to evaluate risk, the fact that use of coercive powers can give rise to a range of adverse consequences in the medium and longer term as well. Those issues have resulted in a range of innovative responses from the Queensland Police Service to utilising the assistance of clinicians to make better and more informed decisions. You've heard evidence about that. The attempts at reform dated back to the 2020 Productivity Commission report in which it was recommended that mental health professionals should be embedded in police communication centres and in police responding, so that there can be an enriching of the way in which responses take place and a sound basis which is as minimally countertherapeutic as can be orchestrated.

You've heard about - this is one of the many acronyms that you've been afflicted with - the mental health intervention program, the MHIP, which was initially introduced some two decades ago in Queensland which has evolved significantly. In 2017, State Coroner Ryan handed down 19 recommendations in relation to the deaths of persons with mental illness, generally at the hands of police, and he called on the Queensland government under recommendation 12 to conduct a review of the MHIP and he recommended the availability of clinically led advice to support police to deal better with people in mental health crisis.

That recommendation was taken up the Queensland Police Service and resulted in a series of changes and recommendations and reforms within the Queensland Police. We mention those because they're relevant to the Queensland Police, but they also have a national significance in that this was the fruit of very careful analysis and reflection by Queensland, so in most respects it's equally appropriate elsewhere in Australia, including New South Wales.

5 It was from that that the Queensland Police Service accepted the appropriateness of having full-time dedicated mental health intervention coordinators, the MHICs, in all of its jurisdictions. That has been implemented, and I can now give you the latest situation, because it's been evolving in the course of your Honour's investigation, and now there are ten established MHICs.

10 There are 15 police districts in Queensland. In ten of them there are established MHICs with gazetted positions that have been filled. There are four others. I won't take your Honour through the names of each of the districts, but there are four others which have an allocated MHIC position. Those have been gazetted, and it is anticipated that they'll be filled, probably by Christmas, but certainly in the very near future.

15 And there's a final area, which is an important one, the Gold Coast, where there is a vulnerable persons coordinator who's been filling the MHIC position, but that's going to be transferred to a MHIC specific role and gazetted accordingly. So this inquest has provided a fill up to the implementation of those changes

20 I've referred to the vulnerable persons command already. That works in conjunction with domestic and family violence in Queensland. It's been a constructive initiative, but it's again been reviewed, and in 2026 that area is going to report directly through the vulnerable persons unit to the commissioner to ensure that there is close supervision of how that is working in conjunction with the MHICs.

30 As you know, those MHICs play an important role and they do quite a number of things which are relevant to this inquest. I'm going to try to avoid bureaucracy speak, but they coordinate strategic responses, including with other agencies. They help with information sharing and collaboration with other agencies.

35 And here's where it gets really relevant to what occurs on the ground, they provide guidance to police members on issues arising within the community on which they need advice and guidance. They assist with the training of police so police become more mental health aware and more trauma informed in their responses to people, who often have a background in trauma. It's again one of the fellow travellers of mental illness symptomology that so often people have had very adverse experiences prior to developing symptomology or in the course of being unwell themselves and being very vulnerable persons in the streets.

45 Another role of the MHICs is to review responses to calls for service and evaluate whether their services are being utilised as they should be or whether there need to be adjustments and further education within the police force about the role of MHICs and what they have to offer.

50 There's a guidebook that's been drafted to assist MHICs and promote consistency of response and performance of duties. Inspector Quinlan

5 explained to you that the role of MHIC, as he put it, is vital for plugging people into the health system. What that means is, not so much focussing upon whether coercive powers need to be utilised, domestic violence orders taken out, but in trying to nudge people voluntarily into receiving assistance from clinicians when they're becoming unwell or their symptoms are becoming worse.

10 You'll recall that Senior Constable McDonnell wrote to the MHIC after his interaction with Mr Cauchi with the intention that the MHIC would assist in providing Mr Cauchi with early intervention support and referral. As it turned out that didn't come to pass, but that's an archetypal aspect of the constructive role of MHICs in relation to persons who are coming to attention because they're acting in a way which is concerning.

15 You have heard quite a deal about the co-responder models in Queensland which have pioneered these efforts. There are different versions of them in different parts of Australia, and as you know, there are two forms of the co-responder model in Queensland. There's the Queensland Police Service
20 co-responder model, which involves a police member who's trained in mental health management, and a clinical nurse consultant teamed together to attend what are identified early as mental health related incidents. That happens regardless of how serious the incident is and how ill the person appears to be. What that means is that where possible that co-responding team - the clinician plus the officer - attend incidents and deal with them as best they can.

25 Acting Deputy Commissioner Kelly said to your Honour that what has been found about this model is that it has played a very constructive role in de-escalating incidents, especially the clinician playing a role in an informed way to deal with the concerns and anxieties of the person with symptoms and
30 constituting a different kind of focus than the person with the police badge on. He said to you that it can lead potentially to an emergency assessment order or an authority, but having the clinician talking to the person about their medication and getting them connected or reconnected to the public health system, it's reduced the number of people that are actually taken to emergency
35 departments.

40 But that's important too, because having mentally unwell people in emergency departments carries its own problems. They can be difficult for the clinicians who are attending to physical issues in the departments. They can involve extra conflict with security personnel there. Often the police officer has to stay with the person while they're there to make sure that further difficulties don't
45 ensue and to make sure that they don't just leave. That can consume many hours. So having as much discernment as possible as to who should be taken under an emergency authorisation is worthwhile and orchestrating that the person cooperate with the exercise and thereby reducing the coercive component of the first response intervention has the kinds of constructive attributes that I've described already.

50 Generally the Queensland Police Service mental health co-response deals with matters at the higher level of acuity and the lower matters are dealt with

by the Queensland Ambulance Service co-responder model.

5 There are seven police districts in Queensland which operate the Queensland Police Service co-responder model, this time including the Gold Coast, a range of areas of Brisbane, Ipswich, Townsville, Cairns and so on. Each program is provided with mental health clinicians from the relevant hospitals and health services within Queensland Health. In short, it seems to be a very positive model, and the early assessments of it have identified that it's worth persisting in and worth significant allocation of resources.

10 There is the unusual situation in Queensland where there's the second model, the Ambulance Service model, which involves persons from the Ambulance Service assisting with police in relation to matters that are not so serious, and 11 out of the 16 health districts have the Queensland Ambulance Service co-responder model. You've heard from Inspector Quinlan, who's spoken about the advantages, having worked himself in a number of shifts with the model, and you've heard, and we detail this in our written submissions, that Centacare Cairns and Far North Queensland partners in recovery have done reviews of the Cairns model. They've been in short very positive.

20 More recently there was an evaluation of a metro south addiction and mental health services, two models, two co-responder models. That was done by an external person. The findings were that the programs, the two of them, provide more timely assessment and prevention of crisis situations. And interestingly, 25 over 70% of co-response contacts result in a person staying at home and not requiring emergency assessment. That's resulted in a significant reduction in the number of emergency assessments, and in terms of again minimising trauma to people by the exercise of compulsion and potential conflict, that too was identified by the assessor as a positive attribute.

30 You heard evidence from Acting Deputy Commissioner Kelly in relation to this as well, and the bottom line is that the Queensland Police Service is very supportive of these two models. They commend them to other parts of Australia. They identify that there is a need for additional resourcing because 35 even these forms of intervention take significant amounts of time. But from a costs benefit point of view, the opinion of the Queensland Police force is that this is very worthwhile.

40 Since the hearings before your Honour, the Queensland Police Service has asked the police minister to communicate with the Minister for Health and Ambulance services seeking an increase in clinician resourcing, so from the health areas and from Queensland Ambulance, to lift the co-responder service to a two shift a day, seven days a week roster across 13 of the 16 police districts. That's an issue that's in process, but it is a change that the 45 Queensland Police Service regards as needed and as likely to bear very worthwhile fruit.

50 You've heard too about the police communications centre mental health liaison service. The acronym for that is just too long to be very helpful. I'll call it the liaison service. That started ten years ago, your Honour, in 2015, and it

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operates between seven in the morning and 11 o'clock at night, seven days a week. It's an interesting and worthwhile initiative which your Honour might commend elsewhere too. It involves a team of clinicians that are embedded in the police communications centre, and their function is to provide assistance to police during incidents where assistance is required. So it's the MHICs plus the clinicians in the liaison service.

They're able to liaise with and have access to information held by Queensland Health and to share that information with police to inform them as to cues and issues which might be being manifested, which may have meaning which the clinicians identify but police if unassisted might not. Again, that's been found to be a very worthwhile exercise, for clinicians to be specific, have access to what is called in Queensland the consumer integrated mental health and addictions application. That contains details of people who have interacted in the public mental health system, so it's a very substantial repository of information likely to be relevant to first responders.

What that does is to provide a situational awareness to police, enable them to back away where necessary, to diffuse when necessary, to be better aware of triggers which might enflame a situation and to deal with scenarios in a non-conflictual way, wherever that's possible. So it helps them in relation to the different categories of interaction.

You heard from Professor Heffernan who is the clinical lead of the liaison service, and in 2024 one of the other initiatives in Queensland was to provide clinicians with a read only access to the Queensland Police computer-aided dispatch system, the ELCAD in real time. That's the other side of things enabling the clinicians to know better what they perhaps need to know in terms of police generated information.

There were nearly 6,000 clinical interventions through the liaison service in Queensland in 2024. That number seems to be rising your Honour; in the first three months of this year there were just under 1500 such interventions, suggesting that the final figure for this year may well exceed 6,000. Again there's been very positive feedback about the service.

There's been a suggestion from the Queensland Forensic Mental Health Service to trial an upgrade in the capability of the liaison service, and you heard about that in evidence; it relates to what's called the Mental Health Rapid Real Time Response. The idea is to enable virtual communication from the clinicians in the liaison service with persons, where that's feasible, and that means that they'll be able to see what's going on, the person can talk to a clinician in the safety and familiarity of their own home or its surrounds for instance, and the hope is that that upgrade again is going to reduce the need for unnecessary emergency assessment interventions. Professor Heffernan was enthusiastic about there being an extension of funding to enable that service to work on a 24 hour a day basis, and the Queensland Police Service is supportive of that position.

So in short there have been significant initiatives and a considerable amount of

5 reflection in Queensland about how best to change the dynamics of police
citizen interactions in the context of mental health. It's an evolving situation
and more is being learned and the valuations are continuing, but what has
been identified from the operation of the co-respond model, and also the
liaison service, is that involvement of clinicians is really constructive, reduces
conflict, it enhances de-escalation, it improves the informedness of responses,
and it reduces the amount of interventions which are characterised by
coercion, and that has a range of flow-on consequences that I've described
already to your Honour.

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I pass now then to a related subject of the emergency examination authorities,
and I propose to be brief about that. Dr Dwyer has referred to this already.
You know what's in s 157B of the Public Health Act. You've heard the
perspectives of multiple personnel, police and clinicians alike, that this was
a change to the law which has not worked as had been hoped. The move as
you know was to move this power to detain and transport a person with mental
illness from the mental health legislation into public health legislation, and the
idea of that was that often the risk posed and the need for assessment arises
out of a combination of factors, not exclusively mental health related.
Sometimes it's, often enough it's drug related or a combination of the two;
intoxication from one provenance or another, plus some mental health
symptomatology, and disaggregating those is just not feasible at the time, and
so it was moved into the public health legislation for ways which are
understandable.

25

However what seems to have happened is that in the peregrination from
mental health to public health, some things have been lost, which are very
much the mainstay of focus in mental health legislation everywhere else in the
country. The key thing that has dropped out as you know is that the focus in
the current legislation in Queensland is on the person being at immediate risk
of serious harm, and with the example of a person threatening to commit
suicide.

30

What's been identified to you by one witness after another, is that there are
a range of other situations too, and that is captured by the risk that the person
will be violent or threatening to other persons. In doing that they may cause
risk to themselves, but it's very important for there not to be a focus from first
responders exclusively on when the person is going to harm themselves. It's
actually worse than that in the Queensland legislation because it refers to the
person being at immediate risk of serious harm, and then it gives an example
of suicide. The risk is that that's going to focus interveners(?) on is this person
suicidal, rather than do they have psychotic symptomatology, which may result
in their doing something very dangerous to someone else.

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You've heard that it is proposed by multiple witnesses that that legislation be
reformed and probably relocated. There's no harm in it being in public health
legislation but insofar as it pertains to mental health issues, it sits sensibly
within mental health legislation, and that's where it exists everywhere else in
the country. So Queensland's initiative in that regard has ended up not being
so constructive.

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5 Inspector Quinlan said "It's a no-brainer for me that there should be appropriate responses that are health-led, and that can be informed by appropriate formulation of the criteria for intervention", and the Acting Deputy Commissioner who gave evidence to you agreed. Professor Heffernan likewise agreed that the power to take someone by coercion for assessment involuntarily to a hospital, is an important power. There are occasions when it needs to be exercised. It needs to be exercised when the person is posting a risk, to others or to themselves, and it's got to be either of those and be really clearly formulated in statute so that those who wield the power, especially police, know exactly what they can and can't do, and what the reasons are for doing so. We've identified the legislation in New South Wales and Victoria in that regard.

15 The assessment of Acting Deputy Commissioner Kelly is that the new Queensland provision has created uncertainty and confusion for frontline police officers, and created an impediment for obtaining treatment for people with apparent mental illness who pose a foreseeable risk to others. The threshold in short is too high. Inspector Quinlan has made suggestions in relation to the reform of s 157B. He has suggested that the focus be on immediate risk to self or others, of the extension of the statutory example so that it isn't focussed on people who are suicidal, and he's suggested that there could usefully be a definition of what constitutes serious harm.

25 The evidence before you is consistent that there needs to be amendment to 157B. We concur with the proposal that that be looked at by an appropriate body, be it the Queensland Law Reform Commission, be it the Queensland Health, be it the Queensland Government, but this is a provision that needs, in the public interest, to be reformed as soon as possible.

30 I move now to the police interactions with Mr Cauchi, and I'm going to deal with some of those briefly and concentrate on the one which was focussed upon by Dr Dwyer, but I'll advert to other ones just quickly as I go through. As you know the first interaction was on 27 May 2021, when police were called to an address with a male screaming, and the sound of someone being hit, and no fewer than eight police officers arrived and spoke to Mr Cauchi, who said he'd become frustrated with the fridge being broken. They realised that he had a schizophrenia diagnosis and that he wasn't taking medication.

40 It is submitted that the engagement by police was appropriate on this occasion. He calmed, there was no reason to take him coercively for further assessment and in general terms this was a professional and appropriate intervention. The next interaction was on 9 September 2021, by Senior Constable Avenell who intercepted Mr Cauchi because he was driving in an erratic way, and Mr Cauchi you will recall produced a medical certificate and returned a negative drug test. Mr Avenell concluded that he was nervous, manifestly not a hundred per cent well, but he'd checked on QPRIME, saw that there'd been a previous incident, but quite a while before. He recognised that he seemed to pose a risk to others, but unfortunately as a police officer doing this kind of work, he sees a lot of bad drivers and there was not enough to identify

to him that he should exercise his coercive powers to mandate an assessment.

5 He was asked whether it would assist highway patrol officers to have a system of alerts or flags in relation to people with a mental health condition who are not at the time taking medication and are coming to the attention of the police, and he said that that would be useful; we don't disagree with that. He agreed with the proposition that police and mental health services need to be able to share information, and as you've heard that is happening increasingly within Queensland.

10 The next intervention took place a little while later in - before I leave that, I beg your pardon - in October of this year a notification went to all Queensland police about the importance of mental health flags on QPRIME, the computer system. It reminded them of the critical importance I quote "of accurately creating and applying such flags" and it identified a recent review which had noted instances where the presence of a flag could have enhanced the effectiveness and safety of police engagement and all officers were instructed to familiarise themselves with the criteria and process for flag creation in respect of mental illness on QPRIME.

20 Going then to July 2022, these were the issues to do with the school, which Mr Cauchi had formed a bit of an absorption with. He had been behaving in a worrying way. He hadn't committed offences, that was looked at, State Intelligence provided a report. They noted that it was concerning conduct, but there was no reason to intervene because he hadn't yet done anything untoward, and there was communication with the school about his behaviour.

30 One option, Inspector Quinlan said, would've been to inform the MHIC of those interactions. That, we acknowledge, would've been a constructive initiative, and one of the things that's taken place, as I have identified already, is that the role of the MHIC is being publicised more throughout the police force, so that members might think that this is a worthwhile thing to do; it's an ongoing educative process.

35 Then there was the interaction about which Dr Dwyer has addressed you already on 8 January 2023, when Mr Cauchi telephoned police and reported his father had stolen his knives. The two police officers attended. I won't rehearse what took place there, but what we say in short was that the two police, Senior Constable McDonnell and Senior Constable Porter, who had their body-worn cameras on, so your Honour's been able review exactly what took place, interacted with the family members and with Mr Cauchi in a suitable and sensitive way. The knives had been removed by Mr Cauchi's father, very sensibly. They concluded that he did not meet the criteria for an emergency assessment. They spoke to him about respecting his parents and being of good behaviour. He seemed calm and broadly cooperative and their interaction resulted in Senior Constable McDonnell emailing Sergeant Morris and Acting Sergeant McDiarmid who was relieving in the role of the MHIC, urging them to follow-up, identifying that this appeared to be the start of
45 a decline in Mr Cauchi's mental health, saying that there may well be other
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calls for service, which of course ended up being right, and urging for there to be follow-up.

5 Now things went wrong. I won't rehearse what took place again. There was an administrative error by a police officer whom counsel assisting has described as "competent and dedicated" as an officer. It was just one of those mistakes that can take place in the context of a system not working as efficiently as it needs to be designed to work, and in a context of a considerable amount of stress on the system at the time.

10 What your Honour needs to know is that the system has been changed so that that could not happen again today. The process now is that if something similar occurs, the computer system doesn't let there be non-responsiveness, in short, and so there are follow-ups and reminders which mean that even if something slips through a crack as it did with Senior Constable McDiarmid, it would not fall through the system. He too has learned from what occurred, and if it had come to his attention, what he said to your Honour was that he would contact the Queensland Health mental health liaison worker and follow up with the family.

20 You would have seen that he was visibly distressed in the witness box, and manifestly an officer who took very seriously what had occurred, had learned from it, and is very committed to no repetition of it, and the changes to the system now mean that this would not recur. You heard evidence from Sergeant Morris as well, who we invite your Honour to conclude was a reliable and very informed source of perspective on these issues. She for that matter described Senior Constable McDiarmid as "a really good officer" and that his oversight had been devastating for him and not typical of how he conducted himself. She identified the changes which are currently now implemented to ensure that this situation doesn't recur.

30 There have been different views about what should've occurred on that date. Understandably and inevitably in spite of the best efforts of everyone involved, infected by hindsight bias, it would've been better had Mr Cauchi through whatever means been linked in with public health clinicians to be looked at with the potential for there to be further intervention and provision of medication and a reassessment of his condition. It was described by one clinician who admittedly said, "with 20/20 hindsight", that was Professor Nielssen, that the incident was a missed opportunity. We submit that was a fair assessment.

40 With 20/20 hindsight something different could have been done and it may well have been advantageous. Would it have stopped what ultimately happened? We don't know, and it's not helpful to speculate. But had there been challenging to a clinician that would have been constructive. If it were to happen again today, that's what would occur. But on the night, so far as the two police officers were concerned, we submit to you that their decision not to use their coercive powers was one which was reasonably open to them on the basis of the information that was before them. In particular, the fact that he was not exhibiting behaviours which suggested he posed an imminent risk to anyone, including himself. He seemed calm, he wasn't threatening, he didn't

have access to knives any further, and the plan was to have follow-up. We refer at para 229 to the new processes.

5 We ask your Honour to conclude that the Queensland police officers who gave evidence before you were professional, forthcoming and most importantly reflective in their evidence. The system in Queensland in relation to police officers is in the vanguard in terms of quality of how police respond to mental illness in Australia. It's been the result of challenges and attempts to learn, often as a result of coronial inquests. But there are two forms of co-responder model, that's the liaison services, improved education, and there are multiple facilities which enable better informed response, and part of that is also the encouragement of members to take time in the way that the two officers did with Mr Cauchi on the incident involving the knife.

15 We conclude then by responding specifically to the recommendations pertinent to the Queensland police service, recommendation 4 is that the Service give consideration to better resourcing of the MHIC. That's been done, and the resourcing is improving. There are MHICs which are either in place or about to be in place right throughout Queensland. We submit that a formal recommendation in this regard is not required. In terms of resourcing more generally, if your Honour is minded to encourage the government to resource the police better so that there can be additional police and clinicians to respond to the escalating number of mental health incidents, you would hear no opposition to us.

25 In relation to recommendation 3, that's the one in relation to amendment of s 157B, we've said what we have to say about that. The draft recommendation 1(c) is to the Royal Australian and New Zealand College of Psychiatrists and to the Commissioner of Police, proposing that they convene with relevant representatives to consider the nature and role of psychiatrists in preparing assessments of fitness for weapons licencing. That is a system that does operate elsewhere. There is no objection to this recommendation being made by your Honour.

35 We highlight that there may be logistical difficulties in implementation, but that's something that a working party could look at and consider perhaps identifying particular categories of persons who should be remitted for clinical assessment. There are probably not enough psychiatrists to assess everybody who applies for a gun licence, and so there are some practical issues in respect of this. But as a matter of principle, in terms of its being given further consideration, we have no objection to it at all.

45 Finally, and this is perhaps a good place to conclude, recommendation 8 from counsel assisting relates to awards being given and recognition more generally being accorded to the first responders in New South Wales Police, ambulance and civilian. We enthusiastically support that. What was done by Inspector Scott was extraordinary, and she carried it through in the way in which she comported herself in the witness box here. It's important to call out the persons who go out on an extraordinary limb in the service of all of us, and we support that your Honour promote the cause of that being formally

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recognised. Thank you for listening.

HER HONOUR: Thank you, Dr Freckelton. Mr Gnech?

5 GNECH: Your Honour, I probably have more to say now thanks to my friend
for the Commissioner. I apologise. I ultimately rely on the written outlined filed
on 20 October, and support and adopt the oral and written submissions made
by learned counsel assisting this morning. Things in Queensland are not
10 perfect, and perhaps not as good, respectfully, as what my friend has made
out. If we can put things in context? It's a little disappointing hearing those
submissions from the Commissioner, because if the MHICs were so important,
if they were as important as described, it wouldn't have taken seven years after
a similar recommendation from the Queensland State Coroner, and
15 unfortunately this major tragedy and this inquest for the MHICs
recommendation to be adopted throughout the State.

As much as a coronial inquest I accept is about looking forward, the fact that
there has been a formal recommendation by the Queensland State Coroner in
20 2017, and at the time of this event had not been implemented, there was no
evidence of it being implemented, it was only during cross-examination of
Deputy Commissioner Kelly that it was announced that there was an intention
to finally adopt that recommendation isn't something that I would ask your
Honour to overlook.

25 On that basis, there's no value in looking backwards too much, but I submit it
certainly is an opportunity for your Honour to reinforce the importance of
properly dealing with coroner's recommendations and doing so in a timely
fashion. Because one does wonder if this tragic event didn't occur and this
inquest didn't occur whether there would be MHICs across each police district
30 in Queensland today. Very briefly, any recommendation your Honour would
make in regards to reform around media reporting my clients would adopt.
Your Honour will recall that during the inquest my clients were subject to
a breach of your Honour's non-publication order by the media. They were also
subject to what I submitted at the time was unnecessary, unreasonable,
35 sensational reporting.

In regards to systems, can I say this? To provide a system with insufficient
resourcing is probably not much better than providing no system at all. In that
regard, and relevant to my client in regard to this matter, your Honour would
40 appreciate from your own experiences that even the most competent operator
across any field, whether it be as a police officer, as a doctor, as a lawyer or as
a coroner, we've all missed emails before and we're subject to human error.
But in adopting some of the wording in counsel assisting's written submissions,
it does - and this is perhaps the most important part of my oral submission to
45 you, your Honour - it remains essential that employers, particularly those of
first response personnel not only provide the systems to function but to ensure
those systems are firstly properly resourced.

50 Secondly, if they are properly resourced, for the eyes to not then shut. That
there then needs to be constant reassessment of that resourcing, because

5 otherwise you have properly competent, committed individuals who are often overwhelmed with their expected responsibilities and workloads, and it is the individual rather than the organisation that bears the brunt of the consequences of that. I submit your Honour would also appreciate that it is unfortunate that systemic issues often only get addressed when a significant event occurs. They are my submissions. I just wish to conclude with my client's specific instructions to again pass on their deepest condolences to the families who have been victims of this tragedy.

10 HER HONOUR: Thank you, Mr Gnech. Mr Casselden?

15 CASSELDEN: My client, notwithstanding what has been submitted today by counsel assisting, stands by its written submissions which are before your Honour. Your Honour will recall that my client Glad Group Pty Ltd is a family run company. Your Honour has received evidence throughout the course of the inquest of the significant impact this tragic incident had on the personnel within Glad. With that in mind, I'd like to read on behalf of Glad a statement. It's in these terms:

20 "On behalf of everyone at Glad Group I would like to extend their sincere heartfelt sympathies to the six families who lost loved ones in the horrific event at Westfield Bondi Junction on 13 April 2024. Glad recognise and thank those families for the compassion they have shown for each other and respect they have shown for all those who gave evidence including Glad team members.

25 Glad also recognises those who were injured during the attack for their dignity and kindness as they endeavour to move on with their lives. Glad hopes this inquest has brought some peace and has provided some answers. On an unimaginable day, Glad staff did their best. They continue to mourn those who died and carry the trauma and shocking memories of the day. Everyone at Glad remains deeply saddened by the loss of their team member and friend, Faraz Tahir. On his first shift at this centre, Faraz was bravely attempting to protect others when he lost his life. Glad send their love and respect as well to Muhammad Taha, who was seriously injured as he also bravely confronted the situation alongside Faraz. Glad stand by him and his family, offering its full support as he continues his recovery.

30 The impact of this tragedy goes far beyond today, and this inquest. It has led to changes. But we hope also a wider understanding of the role of security and the commitment of those who do the job they do. But more than anything else, it has reminded us of the profound losses of the victims' families and the grief they continue to endure. You will remain in Glad's thoughts and prayers".

35 Your Honour has heard from counsel assisting that there's a narrow scope of disagreement between Glad and those assisting your Honour. What must not be lost is that here we are today in an air-conditioned room away from the

5 stress and the viciousness that occurred in April last year, and it's very easy to sit in judgment of those people who were confronted with an unimaginable and vicious, dynamic, fast moving attack, that took place in a very, very small period of time. One must not lose sight of the very fact that Glad employees and its staff are not highly trained police operatives or military operatives. They have received training, and as counsel assisting has submitted, a high level of training through Glad and Scentre. But they're not police officers, they're not equipped with appointments, they are not trained to confront an active armed offender. Their simple role is to observe, report, and escalate.

10 One must not lose sight of what Senior Sergeant William Watt said when he gave his evidence as an experienced expert in this jurisdiction. Your Honour is aware of the Active Armed Offenders Guidelines for Crowded Places published by the Australian and New Zealand Counter-Terrorism Committee. It's apt to remind your Honour what's contained within that very instructive guideline. It says this relevantly:

20 "An individual's initial reaction to an attack may vary depending on a variety of the factors including their situation awareness, the reactions of those around them, and whether they have rehearsed their response. Stress and fear will cause different reactions in individuals and may diminish their ability to process information and make decisions."

25 The divergence of opinion between counsel assisting and Glad and Scentre on those narrow areas, of which your Honour has to make some findings of fact, largely depend on an assessment of evidence. How much weight your Honour ought give, on the one hand, when we take the topic of CR1's competency, a large body of evidence of subject matter experts such as Ms Lulu Fatima, Mr Jerry Helg, Mr Cameron Stuart, and on the other, a very small body of contemporaneous weekly minutes, and the expert opinions of Mr Wilson.

35 When your Honour comes to assess CR1's response, an adjustment has to be made to what was unfolding in that moment as she is absent and hears radio communications and recognises that something is not quite right. Your Honour has seen the CCTV footage. Your Honour has seen the urgency to which CR1 moved back into the control room. Your Honour has to make an adjustment of the very fact that she is playing catch-up, that she is under pressure, and that she may well be very stressed. Not dissimilar to what I've just read out. 40 As your Honour will recall, Senior Sergeant Watt gave evidence that in his experience it's quite common for experienced police officers to make poor decisions whilst under high stress situations.

45 There needs to be an adjustment, as we look back, with the benefit of hindsight. But importantly, when your Honour looks at the evidence, it is overwhelming that the very person who sat in this very witness box, who was the most experienced control room operator, your Honour heard evidence from, gave candid evidence, as counsel assisting accepted, and compelling evidence about her assessment, we submit her reliable assessment of the competency of CR1. She was cross-examined on the weekly operational

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minutes by learned counsel assisting.

5 If I can take your Honour to a passage of evidence and remind your Honour precisely what she said. It's transcript p 661. This is after she's been cross-examined on the operational minutes, and says about line 37:

10 "Q. In your opinion, did you consider that as of April, the start of April 2024, that the female control room operator would be able to appropriately respond to an emergency?
A. That's correct."

At line 47:

15 "Q. I understand she was trying and she was keen, but did she have the skills to appropriately respond in the event of an emergency?
A. Yes."

20 Page 662:

"Q. Had the CCTV skills improved?
A. That's correct."

25 The foot of the page, line 50, quoting from the minutes themselves, then on 10 April 2024:

"Responses from CR1 are too slow. Retraining to be scheduled for CR1.

30 Q. That's in the period you say that she no longer had the issues that you were previously concerned about, is that right?
A. That's correct.

35 Q. And the record of these minutes suggested other people did hold concerns about her competency?"

In answer to that she says in part:

40 "On the days when I was rostered alongside the female control room operator, I didn't have any concerns that I had previously regarding her communication or escalation at that given moment. So that's my opinion on that."

45 Your Honour then asked:

"Q. So your opinion is that she had improved a lot?
A. That's correct, your Honour."

50 Your Honour then says:

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"Since you first started working with her in December?

A. That's correct."

5 It was never put to Ms Fatima that her assessment was in some way
influenced by the very fact that she had trained and supervised her. It was
never put to her that her assessment, her opinion, may have in some way
10 been infected by conscious or unconscious bias. What your Honour has to
grapple with is that from December to April not only did Ms Fatima provide
training and supervision, but she sat in the very same room with CR1 on most
of her shifts. She was the best placed person to give an honest account, an
honest assessment of whether or not she had the requisite skills. Her
15 evidence was cogent, it was exact and it was persuasive, and it has not been
undermined, with the greatest respect, notwithstanding the best efforts by
counsel assisting to move her having regard to what was contained in the
weekly operational minutes.

Some criticism has been made of the control room checklist. It is accepted by
20 Glad that the documentation in relation to CR1 and her initial training in respect
of the checklist was less than satisfactory. But importantly is whether or not
the training occurred, and it's without doubt that it did, and that's found at
transcript p 656, line 45:

"Q. Did you know if that assessment" - that's in reference to the
25 checklist - "occurred in relation to each topic on this document?

A. Yes, it did.

Q. How do you know that?

A. Because I was there throughout. Once I had passed on this
30 information, maybe an hour later or two hours later or maybe the
following day, they would come and assess her.

Q. You participated in a sign-off, if I can use that term, for each
topic that was done by Mr David?

A. That's correct.

Q. In this case Mr David has signed off all these so he was the one
35 responsible for that?

A. In part. I had provided the training and he did the re-checking
40 and assessment once I had confirmed that I'd provided that
particular training."

And that's what happened. But your Honour can't ignore the compelling
evidence of Ms Fatima, simply because it does not fit a particular case theory.
45 Ms Fatima was challenged on the weekly minutes, she did not resile, and she
was firm in her answers. She was an impressive, no nonsense witness which
your Honour will recall.

Mr Stuart also a supervisor gave very clear evidence on the very same topic,
50 and this is found at transcript p 717. Cross-examination by one of the counsel
for the family:

"Q. As at 13 April 2024, did you believe that CR1 could competently perform her role of CCTV operator on her own in an armed active offender emergency?

5 A. Yes.

Q. At 13 April 2024 did you believe that CR1 could competently perform her role as CCTV operator on her own in an armed active offender emergency working quickly?

10 A. Yes.

Q. You had that belief despite being at a meeting on 13 April 2024 where it was noted that CR1's responses were too slow and retraining for her needed to be rescheduled, is that right?

15 A. Yes."

That type of corroboration is also found in the evidence of Mr Jerry Helg, another supervisor who worked closely with CR1. I won't read out the evidence, but it's found at transcript p 598. You then have the evidence of Mr David and Mr Goldberg. It is overwhelming that the very people who are in themselves subject matter experts, experienced in the roles and the responsibilities of a control room operator, have formed the view, notwithstanding challenge by counsel assisting that she was competent, that is CR1, to perform the role and to perform it unsupervised. Your Honour has to grapple with that, and it's defined that CR1 was not competent is in effect to make a finding that each of those witnesses are unreliable and their evidence cannot be accepted. Your Honour could not make that finding having regard to the overwhelming evidence.

30 Can I just very briefly address you on the changes that have taken place within Glad following this tragic incident in April of last year. Your Honour will recall that very, very shortly after the incident, Glad procured and implemented stab proof, or stab resistant vests as a requirement for their security personnel, and that they developed a risk assessment with respect to the requirements to wear a stab proof vest. Your Honour will also recall receiving some evidence that body-worn cameras by security officers are to be rolled out, and that was initiated by Scentre and adopted by Glad.

40 Glad appointed Rod Moolman as the National Security Training and Quality Assurance Manager, very shortly after this incident. They've improved their systems in relation to training through Glad Academy, their learning and management system. They've improved pressure testing and rehearsal style training conducted on security officers and candidates. These particular pressure testing scenarios focus on situational awareness, conflict management, active armed offender and hostile reconnaissance.

45 Mr Moolman conducts assessments and reviews of suitable candidates following that pressure testing. Glad has introduced new comprehensive procedures implemented with respect to selection process for control room operators. There's a suitability assessment, again governed by Mr Moolman.

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Candidates must have worked three months at least onsite and have a thorough understanding of Glad and Scentre's policies and requirements in respect of the control room and more broadly.

5 As your Honour will recall there's now a requirement for CCTV, the control room, that is the CCTV control room to be monitored or manned at all times, and that there be two control room operators present. Control room operators undergo their own specific pressure testing training prior to being assessed and approved. There's ongoing monthly meetings between Glad and Scentre to discuss how to implement new training, improving existing practices and discussing new learnings.

10 Glad also your Honour undertakes monthly meetings with its subcontractors, such as Falcon and discussions are usually along the lines relating to operational compliance, training and general security debriefs. Glad has introduced or implemented a crowded places policy to assist with what Scentre is already doing. Glad has improved its active involvement and participation with industry associations in relation to AAO policies, and Glad is now a part of SHIELD which is run by the NSW Police Force which develops anti-terrorism strategies and raises awareness with security providers.

15 Glad has also your Honour established a comprehensive security training matrix and standard operating procedures for Scentre Group sites. This particular framework aligns Glad and Scentre's training requirements to ensure a seamless induction and learning journey for security officers. This particular programme your Honour covers core security fundamentals, site specific policies and procedures and Scentre's red book emergency response training. Upon completion of both Glad and Scentre induction requirements, officers undergo scenario-based pressure testing.

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30 Importantly your Honour Glad has also developed an enhanced its security training programme and updated all of its relevant policies and procedures, including relevantly having regard to the issues before your Honour, situation awareness policy, active armed offender procedures, radio communication procedures, conflict resolution procedures, hostile reconnaissance procedures, use of force policy, crowded places policy, terrorism awareness packages.

35
40 There are other improvements that have been made since April of last year, which are in the evidence before your Honour and referred to in Glad's outline of submissions. Unless there's anything further arising your Honour, they are Glad's submissions.

HER HONOUR: Thank you Mr Casselden.

45 CASSELDEN: May it please your Honour.

DWYER: Your Honour that completes the oral submissions for today. I note that we are back on Friday to finish the oral submission process, and might I ask that we resume on that date at 9.15 again. We start on that date with the submissions from the Scentre Group.

LTS:DAT

HER HONOUR: Yes, thank you very much. We'll adjourn until Friday at 9.15.

AUDIO VISUAL LINK CONCLUDED AT 3.49PM

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ADJOURNED TO FRIDAY 28 NOVEMBER 2025 AT 9.15AM