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IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

5 THURSDAY 5 FEBRUARY 2026

2024/00139002 - BONDI JUNCTION INQUEST**NON-PUBLICATION ORDERS MADE**

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PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.23AM

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HER HONOUR: Good morning. Today I will deliver my findings in relation to the deaths that occurred at Westfield Bondi Junction on 13 April 2024. I welcome family and friends who are here in court today and some who are here for the first time. I also welcome those who are watching remotely.

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This marks the end of the formal coronial process which commenced on the afternoon of that tragic day. It does not however mark the end of the grieving process for the families and friends of the victims or for those otherwise impacted by the events of that day. I hope that these findings will contribute in some small way to the ongoing individual and complex process of healing.

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While many were affected by the events of Bondi Junction, at the centre of this inquest were the six victims who lost their lives. Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Faraz Tahir, and Pikria Darchia died on 13 April 2024. I know that regardless of the outcome of the inquest and the delivery of these findings the deaths of Dawn, Jade, Yixuan, Ashlee, Faraz and Pikria have forever altered the lives of their families and friends in the most profound and absolute way. There simply are no words that can adequately express the devastation that has resulted. I again offer my heartfelt condolences.

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The Court is immensely grateful to the families for their engagement in this inquest. At the first directions hearing I indicated that the intention of the Court and counsel assisting was to conduct the inquest in a trauma-informed manner that would endeavour to provide much needed answers to the families who lost their loved ones as well as to the wider community. This was with a view to learning lessons in order to save lives in future. I am confident that through these findings this goal will be achieved. But however hard we try to make a process trauma-informed, there is no doubt that participating in an inquest is tremendously difficult. I am grateful for the patience, commitment and grace of the families. Their involvement and advocacy has honoured their loved ones.-informed manner that would endeavour to provide much needed answers to the families who lost their loved ones as well as to the wider community

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My findings are some 837 pages long. There are 23 recommendations directed to government, agencies and other bodies. These recommendations are the product of many months of work and consultation, including after the oral closing submissions in November last year.

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It has only been possible for me to make these recommendations because of the high quality of assistance I have received from my legal team, from eminent experts and from the detailed submissions from interested parties. My recommendations are intended to achieve practical, meaningful and lasting reform in respect of critical areas of urgent need that were identified during the inquest process.

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As soon as I close this inquest today an electronic copy of my findings will be published on the Coroners Court website and they will be emailed to all legal representatives as soon as I finish these remarks. My team has printed two copies of the full findings document for each family and more can be provided as necessary. An executive summary is also available for families.

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Given the length it is neither sensible nor possible for me to read the whole of the findings onto the record this morning. My remarks today are not intended to be a summary of what is contained in my findings. Rather, I propose to speak briefly this morning highlighting particular aspects of my findings and recommendations that are likely to be most significant for the families, those affected and the broader community.

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There are two further matters I wish to acknowledge before I commence my remarks. The first concerns Inspector Amy Scott, whose heroism has been a centrepiece of this inquest. Not only did she act unhesitatingly and with enormous courage and service on 13 April 2024 but she attended court throughout the inquest to provide comfort to others.

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She combined skill and compassion with great humility. She was reluctant to accept praise for her own courage but quick to call out the courage and skill of others; her colleagues in the Police Force, other emergency service personnel, employees based at Westfield Bondi Junction and the civilians present on the day. She now faces a health challenge that was made public over the Christmas period. I wish her and her family all the very best for the road ahead.

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Second, I acknowledge the appalling terrorist attack at Bondi Beach on 14 December 2025, less than a week before I had originally planned to deliver these findings. As a result I determined it was necessary to delay the delivery of my findings until today. I had hoped that our community would not need to grapple again so soon with such a violent event and the devastating consequences wrought by it. I express my heartfelt condolences to all who were impacted, especially the families of those who lost their lives.

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I took some comfort from reports from agencies involved in the response to the attack at Bondi Beach, that lessons learnt from the events at Westfield Bondi Junction, were implemented in responding to that event. It was reported that

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5 paramedics and police worked together in a seamless manner, adopting the joint interoperability principles which were a key focus of this inquest, and which are the subject of recommendations. The ability of paramedics and police in working together at Bondi Beach is said to have contributed to the saving of lives that might otherwise have been lost. It is commendable that measures have so proactively been taken by emergency services, even prior to the handing down of my findings today.

10 I now turn to the events of 13 April 2024. The facts of Saturday, 13 April 2024, are well known and I need only refer to them briefly. This inquest had the benefit of comprehensive CCTV footage from inside Westfield Bondi Junction, and elsewhere, as well as many witness statements. As a result, we have a clear understanding of the events that unfolded on 13 April 2024. On that day just after 3.30pm, Joel Cauchi, in a psychotic state and armed with a 30 centimetre hunting knife began stabbing patrons within Westfield Bondi Junction. In just under three minutes, Mr Cauchi moved through three levels of the centre, stabbing a total of 16 people, six of whom tragically died as a result of their injuries.-centimetre hunting knife began stabbing patrons within Westfield, Bondi Junction

20 His attacks were a quintessential example of an active armed offender, a situation that unfolds rapidly, unpredictably, with serious and ultimately fatal injuries being caused in a very short period of time. Around six minutes after Mr Cauchi commenced his attack, he was fatally shot by Inspector Amy Scott, who had attended Westfield Bondi Junction, in response to calls to emergency services from distressed members of the public. She attended and stopped Mr Cauchi, alone. I have already mentioned Inspector Scott and her actions in these remarks, but they bear repeating. They were extraordinary, calm, skilful and courageous, and actions which clearly saved lives.

30 Other New South Wales Police officers attended Westfield Bondi Junction that day and demonstrated great courage as did New South Wales Ambulance officers, and they continue to carry the weight of that day with them. So too did the security staff present at the centre, including Mr Faraz Tahir, who tragically was undertaking his first shift at Westfield Bondi Junction, when he was fatally injured by Mr Cauchi. Faraz was incredibly proud of his new job as a security guard and responded promptly, along with his colleague, Muhammad Taha, who was also injured by Mr Cauchi.

40 Many other retail employees, some of whom were only very young, responded admirably to an unprecedented and shocking event. They should now take great pride in how they conducted themselves. There were also numerous instances of civilian bystanders who exposed themselves to danger in order to assist the injured. Immediately after Mr Cauchi's death, senior police from Homicide commenced a coronial investigation into the circumstances of Mr Cauchi's actions and the response of relevant agencies and organisations. The scale of that work is rarely seen in this jurisdiction. The investigating police undertook their work with alacrity and with great thoroughness. Their efforts enabled the inquest to commence, run and conclude in an extremely condensed timeframe.

5 The central function of a coronial inquest is to determine the identity of the person or persons who died, as well as the date, place, cause and manner, meaning the circumstances of their death. Each of those matters are addressed in my findings. A key adjunct to the coroner's statutory mandate is the power to make recommendations. I am empowered to make recommendations that are necessary or desirable in relation to any matter connected with a death. The scope of my recommendation function is broad and extends to matters relating to public health and safety. While this inquest cannot ever change what has happened, it is hoped the recommendations will provide opportunities for reform which could in future save lives.

15 As I have stated, my findings run to more than 800 pages. That length reflects not only the serious and important issues addressed at the inquest, but the efforts of all parties in giving statements, answering questions and providing information, documents and detailed submissions. I have been aided immensely in preparing my findings through my review and consideration of those documents. My findings address each of the topics identified in the issues list, including the mental health of Mr Cauchi, his treatment in Queensland, the reasons why he became unmedicated and unwell, and the lessons to be learnt from that. The interaction between Mr Cauchi and police, particularly in Queensland, and whether there were any missed opportunities to reintroduce Mr Cauchi to the mental health system.

25 The events of 13 April 2024 and the actions of staff at Westfield Bondi Junction, particularly those employed by the Scentre Group and its security subcontractor, Glad, and the response of emergency responders with a particular focus being the cooperation and communication between New South Wales Police and New South Wales Ambulance. As I have already indicated this morning, I will not attempt to summarise the totality of my findings now. There are, however, particular aspects of my findings that I wish to specifically address in these remarks, being the mental health care and treatment provided to Mr Cauchi in Queensland, Mr Cauchi's interactions with Queensland Police, and the response to the events on 13 April 2024 by New South Wales Police, New South Wales Ambulance, Scentre and Glad.

40 Turning first to Joel Cauchi's mental health treatment in Queensland. A significant focus of the inquest concerned understanding of the mental health treatment and care that Mr Cauchi received during his time in Queensland. There is no evidence that Mr Cauchi received any mental health treatment during his time in New South Wales. Mr Cauchi was originally treated as a patient in the public mental health care system in Queensland. In 2012 he was discharged into the care of a private psychiatrist, Dr Andrea Boros-Lavack, of the Mi-Mind Centre in Toowoomba. Mr Cauchi remained under the care of Dr Boros-Lavack until early 2020. The care provided by Dr Boros-Lavack in the period from 2012 to September 2019 was exemplary, characterised with personalised, consistent and compassionate treatment.

50 It was during this period that Mr Cauchi's dose of the antipsychotic drug clozapine was reduced with cessation ultimately occurring in June 2018.

Mr Cauchi's prescription of another antipsychotic drug, Abilify, also ceased in June 2019 and the evidence suggests he did not commence any further psychotropic medication after this time. I make no criticism of the decision to trial the cessation of clozapine, nor for that matter, the decision to cease
5 Mr Cauchi's treatment with antipsychotic medication altogether, which was consistent with his wishes and his clinical presentation, and was supported by his mother.

10 However, and in contrast to the care provided in the period from 2012 to September 2019, I have concerns regarding Dr Boros-Lavack's management of Mr Cauchi from October 2019. It was in this period that Mr Cauchi's mother reported concerns to the Mi-Mind Centre, including that he was very unwell since he came off his medication, that he may have been hearing voices and that he was making notes, which suggested he believed he
15 was under satanic control. I do not accept that Dr Boros-Lavack responded appropriately to the early warning signs of relapse which had been identified and raised by Mr Cauchi's mother.

20 While I accept that Dr Boros-Lavack did initially have a suspicion that Mr Cauchi was suffering early warning signs of relapse as evidenced by her issuing a further prescription of an antipsychotic drug to Mr Cauchi on 21 November 2019, I find that she then revised her view as to the early warning signs of psychosis, instead attributing Mr Cauchi's behaviour to his apparent concern that he may have contracted a sexually transmissible
25 infection. Dr Boros-Lavack ultimately failed to take more active steps or to recognise the seriousness of the situation that was unfolding before her. She should have placed greater emphasis on the importance of Mr Cauchi commencing the prescribed medication.

30 However, Dr Boros-Lavack did not do so, because she did not believe Mr Cauchi was experiencing a relapse into psychosis. It was ultimately a major failing that Dr Boros-Lavack revised her view with respect to Mr Cauchi's early warning signs and did not do more to proactively urge Mr Cauchi to resume his medication. This failing was further compounded by the discharge
35 process that occurred in early 2020. That process was inadequate and constituted a clear and serious missed opportunity. All of the expert psychiatrists who assisted the inquest agreed that Dr Boros-Lavack's letter to Dr Grundy, Mr Cauchi's GP based in Toowoomba, dated 19 March 2020, lacked important and significant information concerning Mr Cauchi's mental
40 health.

I find this discharge letter to have been wholly unsatisfactory. That letter needed to contain more information and to be assertive regarding Mr Cauchi needing to see a psychiatrist or to have an urgent review, given the
45 circumstances that his treatment had ceased. Dr Grundy ultimately did not have enough information to know that a review of Mr Cauchi was urgent. In addition, when Mr Cauchi's treating doctors who saw him after his discharge from the Mi-Mind Centre requested material from the Mi-Mind Centre, they did not receive information regarding the early warning signs that were evident and
50 they accordingly did not have the benefit of that information. Despite these

issues, it is important to note that Dr Boros-Lavack's care of Mr Cauchi cannot be said to be the major reason for the events on 13 April 2024. The care that was provided was only one of the many factors that led to this tragic outcome.

5 I now turn to Mr Cauchi's interactions with Queensland Police. Mr Cauchi had several interactions with the Queensland Police Service in the period from around 2021 to 2023, the interaction that assumed most prominence during the inquest was that which occurred on 8 January 2023 at the Cauchi family home, where Queensland Police attended following a report that Mr Cauchi's
10 father had stolen Joel Cauchi's knives.

Following that attendance, an email was sent by the police officers to the local acting Mental Health Intervention Coordinator, unfortunately and due to an oversight, that email was not acted upon. The officer concerned gave
15 evidence at the inquest, he made appropriate and reflective concessions, including that his oversight represented a missed opportunity. I find that he is a competent, committed and responsible police officer, who overlooked a single email amidst a significant workload. I acknowledge that changes have now been made by Queensland Police to ensure that future such referrals are
20 always actioned.

Turning now to security preparedness at Westfield Bondi Junction. Scentre Group as the owner and operator of Westfield Bondi Junction, was well prepared for an active armed offender incident, I accept the expert
25 evidence that their policies can only be described as excellent. The security capabilities on the ground at Westfield Bondi Junction were extensive, including CCTV monitoring, alarms and audio and visual warning systems. Subcontracted security staff employed by the Glad Group were and are required to undergo extensive training prior to and during their deployment, the
30 changes that have been implemented since the event by both Scentre and Glad, including during the process of the inquest, are demonstrative of organisations focused on continual improvement.

However, despite the systems in place, I have found that the CCTV control room operator on 13 April 2024 known by the pseudonym CR1, was not
35 competent to be in the CCTV control room unsupervised on that day. There is clear and cogent evidence that CR1 was not equipped to carry out the critical duties required on 13 April 2024. This finding is not a personal criticism of CR1. Her solo presence in the CCTV control room was the result of a
40 deliberate managerial decision by Scentre and Glad, who were, or should have been, aware that she did not have the skills necessary to discharge this critical role in the circumstances that arose on 13 April 2024.

A further issue which emerged during the inquest was the delay in the
45 activation of alerts and alarms at Westfield Bondi Junction. In particular, a question arose as to whether the alerts could have been deployed earlier, and, if so, whether that may have resulted in a different outcome for the victims, specifically for Pikria Darchia, the second last person to have been attacked and the final victim who succumbed to her injuries. Based on the evidence
50 available to me, I do not consider it was realistically possible for the public to

have been informed of an active armed offender event by making a PA announcement or activating the Centre Management Emergency Override before Mr Cauchi had completed his fatal attacks.

5 Turning now to the police and ambulance response, the response of the
New South Wales Police Force and New South Wales Ambulance to the
incident was commendably rapid and extensive. Individual officers and
paramedics faced with an unprecedented incident went above and beyond.
10 There were, however, issues with the interoperability between the
New South Wales Police Force and New South Wales Ambulance, that is, their
communication and how they worked together.

This is most clearly demonstrated in the context of the declaration of Westfield
15 Bondi Junction as a Hot Zone, requiring all paramedics to exit the building until
concerns about a second offender were resolved. This declaration occurred
one minute after New South Wales Police had identified that there was only
one offender. The fact that the New South Wales Police Force held critical
20 information confirming that there was only one offender one minute prior to the
New South Wales Ambulance Service making the declaration demonstrates
the importance of interagency communication and the need for a framework
which promotes and directs interoperability. While the declaration of a hot
zone and the exit of paramedics did not result in further loss of life, it could
25 have had there been a person with life threatening injuries whose care was
impacted by the exit of paramedics.

In a similar vein, it took nearly two hours for the first multi-agency tactical
command meeting to take place at 5.30pm. This was too long. Extensive
evidence was received as to the importance of interoperability and interagency
30 communication and the benefits of colocation of command centres to support
shared situational awareness. While there are instances of interagency
working on 13 April 2024, the incident at Bondi Junction made clear that
there is an absence of coherent underlying doctrine and a clear framework
for interoperability between New South Wales Ambulance and the
New South Wales Police Force. A joint model of working and the application
35 of the joint emergency services interoperability principles, the JESIP model,
could have mitigated the issues which arose on the day. This is an issue to
which I will return in the recommendations.

I now turn to the formal findings under s 81 of the *Coroners Act*. Each of the
40 six deceased victims died on 13 April 2024 as a result of injuries inflicted by
Joel Cauchi, who attacked those victims with a knife while suffering a psychotic
relapse of his chronic schizophrenia.

Dawn Grace Singleton, Jade Andrea Young, Yixuan Cheng, and Pikria Darchia
45 each died at Level 4, Westfield Bondi Junction, 500 Oxford Street,
Bondi Junction. Dawn and Pikria died as a result of stab wounds, Jade died as
a result of a stab wound to the back penetrating the chest, and Yixuan died as
a result of a stab wound to the central chest structures. Faraz Ahmad Tahir
died at Level 3 of Westfield Bondi Junction as a result of a stab wound to the
50 abdomen. Ashlee Kate Good died at St Vincent's Hospital, Darlinghurst, as a

result of stab wounds.

5 I find that Joel Andrew Cauchi died on 13 April 2024 at Level 5 of Westfield Bondi Junction due to gunshot wounds involving the neck and chest. Mr Cauchi was fatally and lawfully shot by Inspector Amy Scott, an officer of the New South Wales Police Force, during a police operation.

10 I now turn to the recommendations. This morning, I wish to place on the record some of the 23 recommendations I have made. A full list of the 23 recommendations I make is available in part 12 of my written findings. Before I do so, I acknowledge that important changes were implemented by agencies and organisations throughout the inquest once the issues became evident, while others are otherwise in progress or under close consideration. The way in which these recommendations were debated, formulated, and in some cases have already been embraced, underscores the immense potential for inquests to achieve real change and to save lives.

15 I commend these recommendations to the government. They are based on expert evidence and have been the subject of constructive engagement and collaboration between the parties, including government agencies. In particular, the proposed changes to the mental health system, were the subject of consideration by four leading Australian experts and one international expert and then considered by the New South Wales Chief Psychiatrist. Likewise, the proposed recommendations in respect of the interoperability of emergency responders informed by expert evidence from the United Kingdom and the significant benefits posed by the Ten Second Triage system were all embraced by experts in their field.

20 The recommendations are as follows. Firstly, mental health. While much of the inquest focused upon the specific circumstances of Mr Cauchi's mental health care, it was also an opportunity to assess systemic issues and make recommendations directed towards much needed reform to the mental health systems in this country. Several recommendations are directed to the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners, recommending that those bodies give urgent consideration to the development of new guidelines and policies to address issues identified during the inquest, particularly in relation to the care and management of those dealing with schizophrenia.

25 There are also recommendations to government which are geared towards the mental health context in New South Wales and Queensland. This impacts upon all of the community; first responders, the health system, and the population at large. It is a problem which is not going to be resolved without proper planning and execution, coupled with vision and leadership. Now is the time for those steps to be taken.

30 In particular, I wish to put the following recommendations on the record. Recommendation 7, that the New South Wales Government model the need for short term accommodation in the greater Sydney area for those experiencing mental health issues and homelessness, and then establish and

5 support those services and support the establishment and ongoing evaluation of long-term accommodation for those experiencing mental health issues and homelessness, with onsite or easily accessible long-term mental health care, based on the models delivered by Habilis in New South Wales and Haven in Victoria.

Recommendation 8.1, that the New South Wales Government over the next 12 months:

10 (a) Obtain advice from NSW Health on the decline of and related demand for mental health outreach services in New South Wales and on the work being done in this area.

15 (b) Obtain advice from NSW Health as to the additional resources that are required to meet the need for outreach psychiatric services that can effectively collaborate with stakeholders to evaluate and engage people with severe untreated mental illness, including people without housing, and

20 (c) Obtain advice from NSW Health as to a realistic timeframe to achieve these additional resources or services, noting the need to recruit skilled staff and build service capacity.

25 Recommendation 11, that the New South Wales Government consider options to support the roll out of appropriate co-responder models so that they are more widely available throughout New South Wales.

30 Certain of the families submitted that I should make a referral to the Health Ombudsman of Queensland in relation to Dr Boros-Lavack and the treatment she provided Mr Cauchi. In all the circumstances, which are set out more fully in my findings, I have determined to make that referral.

35 That recommendation is as follows. Recommendation 1, I recommend that the Health Ombudsman of Queensland review Dr Andrea Boros-Lavack's care and treatment of Mr Joel Cauchi.

40 Turning now to the issue of active armed offender messaging, the horrific attack at Bondi Beach in December 2025 again stresses the importance of active armed offender messaging. The evidence before this inquest suggested that the messaging is not well-known or understood. In many instances, rather than removing themselves from danger, bystanders filmed the incident that unfolded at Westfield Bondi Junction on 13 April 2024. That particular response was again seen at Bondi Beach in December 2025.

45 As was noted in counsel assisting's oral closing, a recent active armed offender campaign was launched in October 2025 aimed at public safety, with shopping centres to promote safety messages. Despite that campaign, I consider it necessary and desirable to make a recommendation in the following terms.

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Recommendation 13, that the New South Wales Government 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 attendees.

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Turning now to interoperability, as I have already mentioned, a key issue arising from the response to the attack that occurred at Westfield Bondi Junction was the interoperability between New South Wales Police Force and New South Wales Ambulance in their response. This is an issue that may arise in any emergency scenario, and indeed, arose in connection with the events at Bondi Beach, as I have noted. I have therefore made the following recommendation.

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Recommendation 18, that the New South Wales Government in consultation with the Commissioners of the New South Wales Police Force, New South Wales Ambulance and Fire and Rescue and other emergency services agencies as appropriate, convene an urgent working group involving relevant representatives from emergency services to consider development and implementation of an emergency services interoperability philosophy model and framework for New South Wales, including drawing on the evidence from the inquest and from the Joint Emergency Services Interoperability Program, known as JESIP, framework and doctrine in the United Kingdom as appropriate to provide a clear structure and framework for multiagency responses to major incidents.

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Turning now to the Ten Second Triage tool, this inquest had the benefit of expert evidence from Dr Philip Cowburn based in the United Kingdom regarding the Ten Second Triage Tool, which is a novel triage tool designed to be used at any large-scale incident where patient numbers exceed the ability to deliver standard care. The Ten Second Triage tool brings with it significant benefits in a patient-centred multiagency response and interoperability model.

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The Ten Second Triage can be used by any emergency responder and can reduce initial triage time to approximately ten seconds. Utilising the tool enables emergency responders to follow clear steps which are relatively uncomplicated in order to expedite the provision of lifesaving treatment to those in need. The importance and significance of the Ten Second Triage cannot be overstated, and its implementation should be considered by all emergency services.

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Moreover, there is some urgency in its implementation, noting the potential good it could bring to the multiagency response at major incidents. I have therefore made the following recommendation, recommendation 19, that the working group urgently convened by the NSW Government per recommendation 18 consider the implementation of the Ten Second Triage rapid screening tool by emergency services in NSW including having regard to the expert evidence from the inquest as to the significant benefits that may flow from the use of the tool and the need for utilisation of the tool within a broader model of emergency service interoperability as referred to in recommendation 18.

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Turning now to the media. The inquest heard from families about their particular experiences with the media after the aftermath of 13 April. Those accounts poignantly illustrated how some of the media coverage of the incident exacerbated the trauma already being suffered. As a result I have made two recommendations to the Australian Press Council and the Australian Communications Media Authority regarding reporting following a mass casualty incident. I hope that those bodies will take the opportunity to give consideration to the impact reporting may have in the wake of a tragic event and to implement new guidelines and protocols to minimise this.

Finally, and while 13 April 2024 was punctuated by violence and tragedy, it was a day also marked by immense bravery and acts of extraordinary courage. I therefore make the following recommendation, recommendation 14. Given the evidence disclosing exceptional bravery on the part of a number of individuals who confronted Joel Cauchi on 13 April 2024, I recommend that the Council for the Australian Bravery Decorations review the relevant evidence in the inquest and consider an appropriate award in recognition of their actions on that day. Those individuals are Inspector Amy Scott, Ashlee Good, Noel McLaughlin, Damien Guerot and Silas Despreaux, sometimes referred to as the bollard men.

I understand that Faraz Tahir and his colleague Muhammad Taha were appropriately awarded an Australian Security Industry Australian Security Medal of Valour Award in October 2024 for their exceptional bravery on 13 April 2024.

As I conclude, there are many I wish to again specifically acknowledge, each of whom contributed to this inquest. They are as follows. Detective Chief Inspector Andrew Marks of the NSW Police Force and his team. The counsel assisting team Dr Peggy Dwyer SC, Ms Emma Sullivan, Mr Christopher Murphy, instructed by Ms Amber Doyle of the Crown Solicitor's Office and supported by an extended team of dedicated solicitors who I cannot thank enough for the care and effort they have put into assisting me.

The legal representatives of the interested parties in this inquest who worked constructively and collaboratively to assist the Court in conducting this inquest. The office of the Coronial Information and Support Program and the NSW Police Force family liaison officers who have provided invaluable support to the families of those that died and injured victims throughout this process.

Finally, I would like to again and for one final time as part of this inquest express my sincere condolences and deepest sympathy to the families of Dawn, Jade, Yixuan, Ashlee, Faraz and Pikria. I acknowledge the strength and dignity you have shown in your participation and contributions to this inquest. Thank you. I close this inquest.

AUDIO VISUAL LINK CONCLUDED AT 11.04AM