Coroners Court of
New South Wales

Inquest into the deaths at Westfield Bondi Junction on 13 April 2024

Executive Summary

Findings of Magistrate Teresa O'Sullivan
New South Wales State Coroner

5 February 2026

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Findings and Recommendations

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Executive Summary

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1. This Executive Summary sets out key findings and recommendations, which are addressed in further detail in the relevant Parts.

Part 1 Overview

2. On 13 April 2024, Joel Cauchi attended Westfield Bondi Junction (WBJ). Just after 3:30pm, Mr Cauchi commenced an attack during which he stabbed 16 people in a period of just under three minutes.

3. Six of Mr Cauchi's victims tragically lost their lives that day: Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Faraz Tahir and Pikria Darchia.

4. Around six minutes after Mr Cauchi commenced his attack, he was fatally shot by Detective Inspector Amy Scott (Insp Scott), a member of the NSW Police Force (NSWPF) who had attended WBJ that afternoon, alone, in response to calls to emergency services from distressed members of the public.

5. The threat posed by Mr Cauchi, and the widespread trauma that resulted from his actions, was, at that time, unprecedented in NSW.

6. There were many acts of considerable bravery displayed by members of the public, staff working at WBJ, and emergency services personnel. The Court acknowledges the many individuals who responded in a most selfless and heroic manner, in particular those who went to the aid of the injured.

7. 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 circumstances) of their death (per s 81 of the *Coroners Act 2009* (NSW) (the Act)). Under s 82 of the Act, I may also make recommendations that are necessary or desirable in relation to any matter connected with a death.

8. The intention of the Court was to conduct the coronial proceedings in a trauma-informed manner that would endeavour to provide much-needed answers to the families who lost their loved ones and to the wider community, with a view to systemic learning.

9. Consistent with that approach, only two civilian witnesses present on 13 April 2024 were called at the Inquest, both of whom were willing to provide oral evidence. In addition, oral evidence was called from witnesses from NSWPF, NSWA, Scentre (the operator of WBJ), Glad (the security contractor at WBJ), QPS with respect to Mr Cauchi's previous interactions with police in Queensland, medical practitioners who cared for Mr Cauchi in Queensland (QLD), executives from various organisations, and a variety of expert witnesses.

10. The issues explored during the Inquest were informed and guided by the Issues List, which is replicated at **Appendix 5**.

Part 2 Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

11. Part 2 considers Mr Cauchi's mental health history and care in Queensland. There is no evidence he sought or received any mental health care in NSW.

12. I appreciate the insights that the experts and Dr Wright (Chief Psychiatrist of NSW) have contributed over the course of the Inquest.

Mr Cauchi's early life, initial diagnosis and care in the public system (until 2012)

13. Mr Cauchi was born in 1983 and raised in Toowoomba, Queensland. Mr Cauchi was admitted to hospital on two occasions for mental health care, from 26 January to 23 February 2001, aged 17 years (during which time he was first commenced on antipsychotic medication), and from 1 to 15 October 2002 (to manage a medication change to clozapine). Upon discharge in October 2002, Mr Cauchi's diagnosis was schizophrenia.

14. From 2001 to early 2012, Mr Cauchi received care in the community from public mental health teams in Queensland. Mr Cauchi experienced a brief period of mildly increased symptoms in the context of a clozapine brand change in early 2007. In July 2007, Mr Cauchi commenced aripiprazole (Abilify) in addition to clozapine. On 20 December 2011, Mr Cauchi's clozapine dose was reduced from 600mg to 550mg nocte in the public system.

15. In late 2011, certain patients cared for by the Queensland public health system who were stable on clozapine began to have their mental health care transferred to private clinics which were, for the first time, able to prescribe clozapine. Mr Cauchi was last seen by the public health care team in February 2012 and formally discharged in April 2012.

Finding: Mr Cauchi's mental health in the public system (until 2012)

16. It is clear that during the period Mr Cauchi received mental health care in the Queensland public health system, he was displaying positive symptoms of schizophrenia, despite having been treated with at least two medications.

Treatment at the Mi-Mind Centre (2012 to 2020)

17. From March 2012 to early 2020, Mr Cauchi was a patient of Dr Andrea Boros-Lavack at the Mi-Mind Centre in Toowoomba, whom he generally saw on a monthly basis. Mr Cauchi also saw a mental health nurse at Mi-Mind Centre on an approximately monthly basis.

18. On 6 March 2012, Dr Boros-Lavack saw Mr Cauchi for the first time and recorded a diagnosis of chronic paranoid and disorganised schizophrenia, which was in control on Clopine, and Obsessive Compulsive Disorder (OCD). Dr Boros-Lavack gave oral evidence that after receiving a letter/discharge summary from the public mental health team, she revised Mr Cauchi's diagnosis to first episode psychosis, which remitted on clozapine.

19. Shortly after Dr Boros-Lavack started treating Mr Cauchi, his clozapine level started to be gradually decreased over a six-year period, from 550mg in March 2012 to cessation in around June 2018.

20. Dr Boros-Lavack gave evidence that from April 2013, Mr Cauchi's clozapine level was "*sub-therapeutic*", and that Mr Cauchi's 5mg dose of Abilify was also sub-therapeutic for psychosis.

Finding: Whether medication levels were sub-therapeutic

21. I find that Dr Boros-Lavack's evidence with respect to the clozapine and Abilify doses being sub-therapeutic was not correct and was misconceived. It was not supported by the expert evidence.

22. This may have been another aspect of Dr Boros-Lavack's confirmation bias (addressed below) in that she thought the medication was having no effect, in circumstances where it was.

23. On 14 July 2015, private psychiatrist Dr Nicky Stephens (who was previously Mr Cauchi's psychiatrist in the public system) provided a second opinion to Dr Boros-Lavack.

24. On 28 June 2018, Mr Cauchi last took clozapine, under the care of Dr Boros-Lavack.

25. On 28 November 2018, Mr Cauchi's mother (Mrs Cauchi) reported to the Mi-Mind Centre that she was concerned about Mr Cauchi. Dr Boros-Lavack saw Mr Cauchi on that date and considered Mr Cauchi was not psychotic but had a new mannerism or complex tic.

Finding: Concerns on 28 November 2018

26. The experts opined that they could not be certain as to whether Mr Cauchi's tics as at 28 November 2018 reflected a psychotic process. I accept that evidence. It would have been preferable for Dr Boros-Lavack to commence closer monitoring of Mr Cauchi to ensure it was not an early warning sign or possible early warning sign. Given that Mr Cauchi was no longer taking clozapine, it would have been prudent to closely monitor him to ensure he was not experiencing early warning signs of relapse.

27. On 12 June 2019, Mr Cauchi ceased taking Abilify. The evidence suggests Mr Cauchi did not commence any psychotropic medication after this time.

Findings: Decision to cease Mr Cauchi's antipsychotic medications

28. None of the experts considered that a trial of cessation of clozapine was outside of the applicable standards. In light of that, there should be no criticism of the care provided by Dr Boros-Lavack at the stage when clozapine was ceased for Mr Cauchi.

29. Also, none of the experts were critical of the decision to trial taking Mr Cauchi off all antipsychotic medication, which was in line with his wishes and supported by Mrs Cauchi, with the caveat that there had to be a careful explanation of the high chance of relapse and to watch out for early warning signs. Ultimately, all of the experts agreed that it was not unreasonable to cease all medication for Mr Cauchi.

30. Whilst Professor Harris would have preferred for Mr Cauchi to remain on clozapine and a low dose of aripiprazole, he opined that the decision to trial cessation of Mr Cauchi's medication was not unreasonable.

31. Professor Harris opined that it is important to explain very carefully to a patient and their family the benefits and risks of ceasing medication, particularly given the risk of relapse is 90% within two years (and Professor Heffernan, Professor Nielssen and Professor Nordentoft generally agreed with that opinion). The risk of relapse after ceasing clozapine is addressed further below.

32. Professor Large opined that the decision to cease Mr Cauchi's antipsychotic medication was within the RANZCP guidelines.

33. I accept all of the relevant expert opinions.

34. I note Counsel Assisting's submission that I would not be critical of the trial of cessation of clozapine for Mr Cauchi, which was not contrary to any policy or guideline; however, Counsel Assisting submitted that Dr Boros-Lavack did not provide adequate guidance for Mr Cauchi, his

family or GP as to the risk of relapse, and did not adequately monitor him for early warning signs of relapse. I accept this submission.

35. It would have been best practice for Dr Boros-Lavack to have made clear notes about her thought process around the cessation of medication and what actions she took to clearly explain to Mr Cauchi and Mrs Cauchi the risk of relapse, as well as Dr Boros-Lavack's plan if early warning signs emerged. Based on the notes, it is not clear if Dr Boros-Lavack did enough, including to sufficiently explain the risks to Mr Cauchi and his mother.

36. Some of the experts were critical that there was not close enough monitoring of Mr Cauchi. However, Professor Large opined that Dr Boros-Lavack monitored Mr Cauchi closely for around 18 months after ceasing clozapine. Whether Mr Cauchi was adequately monitored is further addressed below.

Findings: Relapse rate

37. I find that at one point in Dr Boros-Lavack's evidence, she clearly did misstate the relapse rate. That appears to have been a mistake, whereby she said the figures the wrong way around.

38. It is clear from what Dr Boros-Lavack said at other times in her evidence that she did understand what the relapse rate was. That is, Dr Boros-Lavack understood that per literature, the risk of not relapsing was 14%.

39. Dr Boros-Lavack nonetheless believed or hoped that Mr Cauchi was in that 14%. Evidently, Mr Cauchi was actually in the 86% (to 90%) of people who would relapse after ceasing medication.

Concerns from October 2019

40. I have concerns regarding Dr Boros-Lavack's management of Mr Cauchi's care from October 2019, which is a period when Mrs Cauchi was reporting concerns to the Mi-Mind Centre.

41. Mrs Cauchi reported concerns to Mi-Mind Centre regarding Mr Cauchi's mental health (or functioning) on: 17 October 2019 (approximately four months after he ceased all psychotropic medication), 23 October 2019, 13 November 2019, 20 November 2019, 28 November 2019, and between 3-5 December 2019.

42. The concerns expressed by Mrs Cauchi in that period included: concerns for relapse; that Mr Cauchi did not have the skills for independent living; that he was "*very unwell since he came off his medication*" and had been doing "*so much better*" when on Abilify; it was reported that he may be hearing voices and was "*[w]riting a lot of notes +++ at home and leaving them about – Mother read some notes with some content of under Satanic control…*"; and that he was "*very confused*".

43. Dr Boros-Lavack's re-prescription of antipsychotic medication for Mr Cauchi is set out in my findings below.

44. From around November 2019 to mid-2020, Mr Cauchi also displayed concerns regarding his sexual health, which prompted him to seek treatment a number of times.

45. Between 12 November 2019 and 30 January 2020, Mr Cauchi also corresponded with the Mi-Mind Centre on three occasions: requesting via email to discuss ideas for a "*porn free phone*" and other devices and saying that he would consider seeing a specialist if that was recommended; messaging another Mi-Mind Centre psychiatrist to ask, "*Hey do you do advice for mens sexual performance at all?*"; and asking a nurse whether clozapine had "*damaged his bodys [sic] temperature system*", as he now felt hotter and colder than he used to.

46. On 8 January 2020, Dr Boros-Lavack and RN Andrea Brooks saw Mr Cauchi. Dr Boros-Lavack's note indicates Mr Cauchi was "*totally well*", and the plan included to continue with no medications. Mr Cauchi said he was moving to Brisbane and agreed to monthly Skype appointments with Dr Boros-Lavack and monthly Skype or phone calls with RN Brooks.

47. On 12 February 2020, Mr Cauchi attended his final face-to-face appointment at the Mi-Mind Centre with RN Brooks. RN Brooks considered there was no evidence of psychosis. Mr Cauchi asked to speak to a therapist about a lack of confidence with sexual knowledge and was informed there were no such therapists available at that time.

48. On 14 February 2020, Mrs Cauchi phoned Mi-Mind Centre to express further concerns, including that Mr Cauchi was not well and Mrs Cauchi was "*worried if he moves to Brisbane he may become homeless*".

49. On 17 February 2020, Mr Cauchi attended his final appointment with Dr Boros-Lavack via Skype. Dr Boros-Lavack considered he had no signs or symptoms of a psychiatric disorder on this date.

Discharge from Mi-Mind Centre (March 2020)

50. On or around 15 March 2020, Mr Cauchi moved from Toowoomba to a share house in Brisbane.

51. On 16 March 2020, Mr Cauchi was unable to attend a Skype appointment with Dr Boros-Lavack, as his Skype was not working and he had "no sound". Mr Cauchi advised the Mi-Mind Centre receptionist that he had moved to Brisbane, and it appears the receptionist informed Dr Boros-Lavack that Mr Cauchi was accordingly no longer eligible for Skype appointments.

52. On 17 March 2020, the Mi-Mind Centre receptionist phoned Mr Cauchi and advised he would need to be referred to his GP in Brisbane. Mr Cauchi indicated he did not yet have one and would advise the Mi-Mind Centre when he did. There is no evidence that Mr Cauchi did so.

53. On 19 March 2020, the receptionist wrote (using a precedent), and Dr Boros-Lavack signed, a letter to Dr Richard Grundy (in Toowoomba). Dr Grundy had been Mr Cauch's GP since 2001. The letter was sent on 23 March 2020, and it included:

> *I am therefore discharging Joel back into his and your kind ongoing care. Please recall Joel to discuss his options and referral to an alternative psychiatrist if required.*

54. Dr Grundy did not re-call Mr Cauchi and did not see Mr Cauchi after this time.

Findings: Mr Cauchi's diagnoses

55. As a starting point, there were definitional issues with respect to Mr Cauchi's diagnosis, and the meaning of certain terms was not clear. This included confusion with respect to the terminology "first episode" and "chronic" in connection to schizophrenia. It was also unclear whether the labels "first episode" schizophrenia and "first episode" psychosis were being used interchangeably in some contexts.

56. The common position of the expert psychiatrists appears to be that Mr Cauchi did not have first episode psychosis (or first episode schizophrenia).

57. The submissions on behalf of Dr Boros-Lavack accepted that the expert psychiatrists did not agree with Dr Boros-Lavack's characterisation that Mr Cauchi had prolonged first episode schizophrenia, however, submitted that the terms used are far from clear.

58. Counsel Assisting submitted that Dr Boros-Lavack's use of the term "first episode" was a recent invention (noting all experts characterised it as chronic schizophrenia). However, the records make clear that it was not a recent invention.

59. The experts opined that Mr Cauchi did have chronic schizophrenia.

60. It appeared that Dr Boros-Lavack herself understood that Mr Cauchi's schizophrenia was chronic (and she recognised that first episode schizophrenia could be chronic), however, her evidence regarding this was difficult to understand. The submissions on behalf of Dr Boros-Lavack acknowledged that Dr Boros-Lavack's evidence was confusing in this regard, but that Dr Boros-Lavack did at times say it was chronic.

61. Dr Boros-Lavack's evidence was inconsistent and confusing at times, and whilst she said at various times that it was chronic, she also gave evidence regarding Mr Cauchi being in full remission. Ultimately, Dr Boros-Lavack deferred to the experts in accepting that Mr Cauchi was likely to be psychotic in April 2024.

62. The Australian-based expert psychiatrists all agreed that Mr Cauchi had treatment resistant schizophrenia (although international expert, Professor Nordentoft, ultimately did not agree with that terminology).

63. Professor Heffernan opined that Mr Cauchi, by definition, had treatment resistant schizophrenia, which is commonly defined as a lack of response to two or more antipsychotic medications given in an adequate dose for at least six to eight weeks. Professor Nielssen agreed.

64. In addition, I accept Professor Nielssen's opinion that it is likely Mr Cauchi's OCD and schizophrenia were part of the one syndrome and hard to separate. It is difficult to say whether the OCD was an adverse effect of clozapine; however, noting Mr Cauchi had OCD symptoms prior to starting clozapine, I find it is likely to be part of the one syndrome.

Findings: Dr Boros-Lavack – Standard of care

65. From 2012 until September 2019, Dr Boros-Lavack's care of Mr Cauchi was exemplary. In that period, Dr Boros-Lavack's care of Mr Cauchi was very personalised, consistent and compassionate. Dr Boros-Lavack was available to consult with Mr Cauchi and, in combination with the Mi-Mind Centre nurses, provided a well-rounded mental health service to Mr Cauchi.

66. An exception to this is that in response to the "*new mannerism or complex tick [sic]*" noted by Dr Boros-Lavack on 28 November 2018, it would have been preferable for Dr Boros-Lavack to commence closer monitoring of Mr Cauchi, as I have found above.

67. The standard of care provided by Dr Boros-Lavack during the period of 2012 to September 2019, however, sits distinctly from the care provided from October 2019.

Response to concerns raised by Mrs Cauchi and re-prescribing medication

68. It is submitted on behalf of Dr Boros-Lavack, contrary to Counsel Assisting's submissions, that Dr Boros-Lavack responded adequately to early warning signs raised by Mrs Cauchi. I do not accept that submission.

69. Professor Harris opined that Dr Boros-Lavack may have been "*overly optimistic*" that Mr Cauchi would restart medication if he became unwell again; Professor Heffernan considered that a more assertive approach in terms of encouraging restarting medication needed to be considered (and that Mr Cauchi could also have been referred to a public mental health team

for review or assistance); and Professor Nordentoft opined that Mrs Cauchi's reported concerns in 2019 were not taken seriously enough. I accept all of those opinions and also consider that Professor Nordentoft's comments are relevant to the period in 2020 when Dr Boros-Lavack saw Mr Cauchi.

70. In terms of whether Dr Boros-Lavack recognised "early warning signs" of relapse or psychosis, it was submitted on behalf of Dr Boros-Lavack that: "*The consistent evidence of [Dr Boros-Lavack] was that she did accept that Mrs Cauchi's concerns were "early warning signs of relapse"* and *"[t]hat evidence was unchallenged and would be accepted. The very fact that [Dr Boros-Lavack] issued the prescription is a corroboration of her acceptance that she recognised that Mrs Cauchi's concerns were indicative of early warning signs of relapse. The alleged "major failure" on [Dr Boros-Lavack]'s part is not established on the evidence*."

71. I do not accept the submission on behalf of Dr Boros-Lavack. Dr Boros-Lavack did initially have a suspicion that Mr Cauchi had early warning signs, and she responded by issuing a prescription for medication on 21 November 2019 prior to even having the opportunity to consult with Mr Cauchi, which demonstrates that her index of suspicion was high.

72. However, Dr Boros-Lavack then revised her view and came to a different conclusion. Dr Boros-Lavack attributed the situation completely to Mr Cauchi's concerns regarding having an STI. Dr Boros-Lavack failed to take more proactive action or to recognise the seriousness of the situation. She should have placed greater emphasis on the importance of Mr Cauchi commencing the prescribed medication. However, Dr Boros-Lavack did not do so because she did not believe Mr Cauchi was experiencing psychosis.

73. It was a major failing that Dr Boros-Lavack revised her view with respect to early warning signs and did not more proactively agitate for resumption of medication.

74. The key events in relation to the above were as follows:

    (a) On 20 November 2019, Mrs Cauchi contacted the Mi-Mind Centre to advise of her concerns that Mr Cauchi was not doing very well since ceasing Abilify and that he may be hearing voices (and RN Brooks recorded "*Writing a lot of notes +++ at home and leaving them about – Mother read some notes with some content of under Satanic control …*"). RN Brooks saw Mr Cauchi (with Mrs Cauchi present) and Mr Cauchi agreed with the re-introduction of "psychotropics" but desperately wanted to avoid sedation.

    (b) On 21 November 2019 at 8:36am, Dr Boros-Lavack recorded a plan to prescribe Mr Cauchi Abilify tablets 10mg mane. Dr Boros-Lavack did not see Mr Cauchi that day.

    At 11:19am, RN Brooks recorded a note in relation to having seen Mr Cauchi face-to-face on his own on that date, which included: "*Plan: Joel will self monitor symptoms and self determine if he will re-start medication. | Does not want to re-start medication at this time and has taken script*".

    (c) On 28 November 2019, Dr Boros-Lavack and RN Brooks saw Mr Cauchi. Dr Boros-Lavack's note from that date includes: "*Mum was contacted by telephone, who told Joel to restart Abilify for relapse prevention based on his EWSR*" and "*[n]ot keen to restart Abilify, because of the dysphoric feelings on it in the past, but happy to restart Rexulti if not going well mentally to prevent relapse of schizophrenia. Plan: start Rexulti 1mg mane x one week then 2mg mane (two weeks trial pack provided) when ready for EWSR.*" The reference to "EWSR" appears to be shorthand for "early warnings signs of relapse".

    (d) On 3 December 2019, Mrs Cauchi reported to Mi-Mind Centre that Mr Cauchi's relative had located a medication used for HIV. On 4 December 2019, RN Brooks contacted Mrs

Cauchi via phone and Mrs Cauchi remained concerned about Mr Cauchi, including that he was "*very confused*".

(e) On 5 December 2019 at 11:11am, RN Brooks noted that she had advised Mrs Cauchi that Mr Cauchi "*is to start taking the Rexulti medication today and to consider his compliance and adherence to Drs management*".

Mr Cauchi then called RN Brooks. RN Brooks' note at 11:48am includes: "*Advised Joel his prescribed management plan is to re-start medication and begin taking the Rexulti. He wants to discuss this with Dr [Boros-Lavack] as he feels mentally well*."

It appears a clinical meeting then occurred between Dr Boros-Lavack and RN Brooks. RN Brooks' note at 5:20pm includes: "*Discussed at clinical meeting … Encourage start of medications Rexulti, especially if Joel notices any EWS or deterioration … P/c to mother to decrease her own anxiety | Informed her currently Joel is m anaging [sic] well and to continue with his holiday and start med if EWS appears"*.

75. I accept the evidence of the expert psychiatrists that Mr Cauchi did not reach the relevant threshold to receive involuntary treatment whilst he was receiving care at the Mi-Mind Centre. Accordingly, it was Mr Cauchi's decision as to whether he took medication. Nevertheless, there was a missed opportunity for Mr Cauchi's medication to be re-introduced between 20 November 2019 and 5 December 2019.

76. I again come back to Dr Boros-Lavack's confirmation bias towards confirming the view that Mr Cauchi had experienced first episode psychosis and was not relapsing, as she had indicated in the Therapy Event/Termination of Treatment form dated 28 June 2018 (in relation to ceasing clozapine). Dr Boros-Lavack minimised Mr Cauchi's early warning signs and in some instances, embellished how well he was doing.

77. As an example, on 8 January 2020 Dr Boros-Lavack recorded in her notes that Mr Cauchi was "*totally well*". Clearly, having regard to the recent reports from Mrs Cauchi, this was not the case. This is also an example of Dr Boros-Lavack being overly optimistic and downplaying the gravity of what was occurring with respect to Mr Cauchi's mental health.

78. On 14 February 2020, Mrs Cauchi called the Mi-Mind Centre to express further concerns regarding Mr Cauchi. Mrs Cauchi advised Mi-Mind Centre on that date that Mr Cauchi was not well, she was worried about him moving to Brisbane as he could not seem to look after himself, and she was worried that if he moved to Brisbane, he may become homeless.

79. The information reported by Mrs Cauchi on 14 February 2020 should have raised greater concern for Dr Boros-Lavack in terms of her suspicion of relapse.

80. Dr Boros-Lavack next saw Mr Cauchi on 17 February 2020, which was via Skype rather than in-person (with Dr Boros-Lavack being in Caloundra). The plan recorded by Dr Boros-Lavack on 17 February 2020 included for Mr Cauchi to continue with no medication.

81. Notably, that 17 February 2020 note does not refer to the call from Mrs Cauchi on 14 February 2020. Also, whilst Dr Boros-Lavack was not aware at the time, the 17 February 2020 appointment ended up being Dr Boros-Lavack's last appointment with Mr Cauchi (noting the attempted appointment in March 2020 did not ultimately go ahead).

82. There also does not appear to be any record made by Dr Boros-Lavack in the Mi-Mind Centre records that specifically refers to Mr Cauchi's notes relating to "*under Satanic control*" (which is recorded in Mi-Mind Centre nursing notes dated 20 November 2019).

83. It is difficult to assess (with reference to her notes) whether Dr Boros-Lavack had an adequate contemporaneous appreciation of Mr Cauchi's risk of relapse, and what (if anything) she said during consultations regarding the serious risk of relapse and what needed to happen if there were early warning signs.

84. There seems to be a serious deficiency in Dr Boros-Lavack's note-keeping, particularly in the later part of Mr Cauchi's care, during the period when Mr Cauchi was coming off medication and Mrs Cauchi was reporting concerns. The adequacy of these notes is relevant to the issues in this Inquest. I accept that the notes are not of a high standard, and this may explain the lack of sufficient information in the letters that Dr Boros-Lavack wrote.

85. It is difficult for me to comment on the adequacy of the remainder of Dr Boros-Lavack's notes in the absence of expert opinion on that issue.

Discharge from Mi-Mind Centre in March 2020

86. I accept all of the expert opinion with respect to Mr Cauchi's discharge from Mi-Mind Centre. All of the expert psychiatrists agree that Dr Boros-Lavack's letter to Dr Grundy dated 19 March 2020 lacked important and significant information concerning Mr Cauchi's mental health. I find that was wholly unsatisfactory.

87. I accept Counsel Assisting's written submissions as to the three problems that existed with that discharge/referral process, other than with respect to whether it was appropriate for Dr Boros-Lavack's referral to be made to Dr Grundy.

88. The most deficient aspect of the handover was a lack of information in the letter from Dr Boros-Lavack to Dr Grundy. That letter needed to contain a lot more information, and to be assertive regarding Mr Cauchi needing to see a psychiatrist or have an urgent review, in circumstances where his treatment had ceased. Dr Grundy did not have enough information to know that a review of Mr Cauchi was urgent.

89. That letter should have contained more details about the concerns reported by Mrs Cauchi, updated Dr Grundy as to the events that had transpired, provided details with respect to Mr Cauchi's medication, and conveyed to Dr Grundy that Mr Cauchi needed to be urgently and closely reviewed during this period. It also would have been helpful for the letter to state that Mr Cauchi needed ongoing psychiatric care in Brisbane.

90. Dr Boros-Lavack could have referred Mr Cauchi directly to a psychiatrist in Brisbane by way of a specialist-to-specialist referral (valid for three months), as raised by expert GP Dr Kruys. However, I am not critical of Dr Boros-Lavack for not doing so, given Mr Cauchi's transient movements.

91. Given the specialist-to-specialist referral did not occur, it was appropriate for the referral to be made back to Dr Grundy, who could have then organised a referral to a psychiatrist in Brisbane. Whilst Mr Cauchi was no longer living in Toowoomba, Dr Grundy had been Mr Cauchi's GP for 18 years, and Mr Cauchi still had significant ties to Toowoomba, including his parents who still lived there. In the circumstances, Dr Grundy would have been the most appropriate person to receive the discharge letter. Also, arranging a referral to a new psychiatrist falls more within the role of a GP than a psychiatrist in any event, and Dr Grundy recalling Mr Cauchi urgently may have been more likely to have a successful outcome than a specialist-to-specialist referral. If the discharge letter from Dr Boros-Lavack to Dr Grundy was as comprehensive as it should have been, I would hope that further constructive steps would have then been taken by Dr Grundy to

ensure Mr Cauchi was cared for by another GP or a psychiatrist, such as by referring Mr Cauchi to a GP in Brisbane.

92. I note the concessions made on behalf of Dr Boros-Lavack with respect to the inadequacies in Mr Cauchi's discharge, per the written submissions on behalf of Dr Boros-Lavack. Those concessions are appropriately made.

93. In those written submissions, it is conceded that the wording of the discharge letter was "*a missed opportunity for a more comprehensive handover*" and that there were "*deficiencies in the manner she discharged [Mr Cauchi] from her care*". There are many concessions made on behalf of Dr Boros-Lavack with respect to Mr Cauchi's discharge in those written submissions. However, they do not seem to appreciate the urgency and risk that were involved at the time of discharge, and I consider that it was a serious missed opportunity.

94. The reasons Mr Cauchi was lost to follow-up are more complex than Dr Boros-Lavack's failure to provide sufficient information via the discharge letter. It is also only speculation whether alternative wording in the discharge letter would have made a difference.

95. It was submitted on behalf of Dr Boros-Lavack that Dr Boros-Lavack's care cannot be suggested to be a material cause for Mr Cauchi's actions more than four years after his discharge.

96. I accept that Dr Boros-Lavack's care of Mr Cauchi cannot be said to be the major reason for the events on 13 April 2024. That care was part of a matrix and was only one of the factors that led to this tragic outcome.

97. Having said that, the content of the discharge letter can appropriately be described as a serious missed opportunity and alternative wording in that letter would have been appropriate. It appears the consensus amongst the experts was that additional information was required in Dr Boros-Lavack's letter to Dr Grundy.

Finding: Dose of Abilify prescribed on 21 November 2019

98. The Mi-Mind Centre records suggest it is more likely that on 21 November 2019, Dr Boros-Lavack intended to prescribe one Abilify 10mg tablet per day, rather than 5mg daily (as Dr Boros-Lavack indicated in her evidence).

99. This is supported by the fact that in the "Prescription History" section of Mr Cauchi's Mi-Mind Centre records, previous Abilify prescriptions consistently specified "half mane" or "half a tablet mane", whereas on 21 November 2019 "one mane" is recorded. Dr Boros-Lavack's practice was therefore usually to specify in the records when the dose was a half (rather than one) tablet. A prescription of 10mg would also be more consistent with Dr Boros-Lavack's belief that she suspected a relapse.

100. Dr Boros-Lavack gave evidence that she also had a conversation, or conversations, with Dr Grundy regarding Mr Cauchi's discharge, which was not documented. Dr Grundy gave evidence that he did not believe that any such phone call(s) occurred.

Findings: Whether phone call(s) occurred between Dr Boros-Lavack and Dr Grundy

101. I accept Counsel Assisting's submission that it is not necessary for me to make a finding as to whether a phone call(s) occurred between Dr Grundy and Dr Boros-Lavack at around the time of Mr Cauchi's discharge from Mi-Mind Centre. This is because even if there was a call, Dr Boros-Lavack did not pass on the crucial information about Mrs Cauchi's concerns of decline over the past five months, as Dr Boros-Lavack herself had dismissed any likely concerns. I also

accept Counsel Assisting's submission that this was particularly problematic in circumstances where every letter to Dr Grundy over the previous eight years indicated Mr Cauchi was doing very well and Mrs Cauchi believed he was doing very well.

102. Ultimately, it was submitted on behalf of the Good, Singleton and Young families that I should make a referral to the Health Ombudsman of Queensland in relation to Dr Boros-Lavack.

Recommendation 1: To the Health Ombudsman of Queensland

103. I have determined to make a referral to the Health Ombudsman of Queensland in relation to Dr Boros-Lavack. The basis for this referral is the evidence before me as to the care provided by Dr Boros-Lavack to Mr Cauchi from October 2019 (when Mrs Cauchi was reporting concerns) and the discharge process including, in particular, Dr Boros-Lavack's discharge letter dated 19 March 2020.

104. ***Recommendation:*** *I recommend that the Health Ombudsman of Queensland review Dr Andrea Boros-Lavack's care and treatment of Mr Joel Cauchi.*

105. I make the following findings with respect to RN Schwarz and RN Brooks (mental health nurses at the Mi-Mind Centre).

Findings: RN Schwarz and RN Brooks - Standard of care

106. Mr Cauchi received a good mental health service from the nurses at Mi-Mind Centre.

107. I was impressed by the evidence of RN Brooks and RN Schwarz. I agree with Counsel Assisting's submission that these nurses appeared to be both professional and compassionate.

108. RN Brooks and RN Schwarz were consistent, available, open, and flexible when providing mental health care to Mr Cauchi.

Treatment from GP Dr Grundy

109. From 2001 to 2019, Mr Cauchi's private treating GP in the community was Dr Richard Grundy.

Findings: Dr Grundy (GP) – Standard of care

110. I accept that the overall care provided by Dr Grundy to Mr Cauchi was adequate, reasonable and appropriate.

111. Dr Kruys opines there was a "missed opportunity" on the part of Mr Cauchi's GP team to assist Mr Cauchi with follow-up care from a GP and/or psychiatrist in Brisbane and that whilst not routinely part of care when not requested by a patient, it "*could have been considered given Mr Cauchi's mental health history and the risk associated with no follow up care*".

112. I accept Counsel Assisting's submission that Dr Grundy should have taken a more proactive approach at the time of Mr Cauchi's discharge from the Mi-Mind Centre (in March 2020).

113. I also accept Counsel Assisting's submission that, in the circumstances of this matter, there is no reason to be overly critical with respect to Dr Grundy. Counsel Assisting submitted it is regrettable that Dr Grundy did not recall Mr Cauchi (who was his patient for a long time);

however, there was no information in the discharge letter from Dr Boros-Lavack to Dr Grundy dated 19 March 2020 as to Mr Cauchi's recent decline.

Care after Mi-Mind Centre (March 2020 onwards)

114. From 27 May 2020 to 30 April 2021, Mr Cauchi saw GP, Dr Nathan Ruge on a number of occasions in Brisbane.

115. Mr Cauchi saw two psychiatrists after the Mi-Mind Centre, each on one occasion. On both occasions, Mr Cauchi was referred by Dr Ruge and Mr Cauchi requested from them a report for an application for a Statement of Eligibility (in relation to firearms).

116. First, on 26 November 2020, Mr Cauchi saw psychiatrist, Dr Amitava Sarkar, at Cornwall Street Medical Centre in Brisbane. Mr Cauchi left before the assessment could be completed. On 2 December 2020, Dr Sarkar was provided with certain letters by Mi-Mind Centre (in response to a request for information).

Findings: Dr Sarkar (psychiatrist) – Standard of care

117. I find that no criticism should be made in terms of Dr Sarkar having the opportunity to do more with respect to the care of Mr Cauchi.

118. Dr Sarkar did not have available the information that Dr Boros-Lavack was aware of regarding concerning signs of deterioration in Mr Cauchi's mental state from at least October 2019, as that was not provided to him, and there was not much he could do without that information. Mr Cauchi also left the appointment with Dr Sarkar before the assessment was complete. I accept that the chance of Mr Cauchi being linked back into services after consulting with Dr Sarkar would have been greatly improved by an adequate discharge letter from Mi-Mind Centre being available to Dr Sarkar.

119. On 18 January 2021, Mr Cauchi saw psychiatrist, Dr Sagir Parkar, at the Oxford Clinic in Brisbane. It appears that on 19 January 2021, Dr Parkar was provided with certain letters by Mi-Mind Centre (in response to a request for information). On 20 January 2021, Dr Parkar wrote a letter in support of Mr Cauchi's Statement of Eligibility application, which is addressed in Part 3.

Findings: Dr Parkar (psychiatrist) – Standard of care

120. The main issue in terms of Dr Parkar's care of Mr Cauchi related to the Statement of Eligibility application, which is dealt with separately in Part 3 of these findings.

121. The real problem faced by Dr Parkar was a lack of information provided by Dr Boros-Lavack as to the signs of deterioration in Mr Cauchi's mental health. Information regarding Mr Cauchi's early warning signs of relapse would have been critical to Dr Parkar's assessment of Mr Cauchi for the purposes of the Statement of Eligibility application. Dr Parkar did not have the benefit of the information as to Mr Cauchi's decline.

122. This underscores the need for a comprehensive and readily accessible summary upon a patient's discharge.

123. Following Mr Cauchi's final 30 April 2021 appointment with Dr Ruge, there is no evidence in the Medicare records that Mr Cauchi saw a doctor or mental health practitioner (such as a GP, psychologist or psychiatrist) from 1 May 2021 to 12 November 2023, a period of approximately two and a half years.

Findings: Dr Ruge (GP) – Standard of care

124. Dr Ruge impressed as a thoughtful and skilled practitioner. I am not critical of the care provided by Dr Ruge to Mr Cauchi.

125. On 13 November 2023, Mr Cauchi saw GP Dr John Pietsch at Northpoint Medical in Toowoomba, for the purpose of renewing his Queensland driver licence, which was expiring the next day. This was the first and only consultation with Dr Pietsch. Dr Pietsch completed a medical certificate and noted that Mr Cauchi should remain on an "M" category licence.

126. On the same date, Dr Pietsch wrote a letter to Dr Boros-Lavack requesting information and noted Mr Cauchi was not "*frankly psychotic*" and he could not identify a reason for an ongoing "M" on the licence. On 16 November 2023, Dr Pietsch was provided certain letters by Mi-Mind Centre (in response to his request for information).

Findings: Dr Pietsch (GP) – Standard of care

127. I am not critical of Dr Pietsch's care of Mr Cauchi. I also appreciate that Dr Pietsch was a candid and self-reflective witness.

128. The problem for Dr Pietsch (as was the problem for others) was that he did not have information from Dr Boros-Lavack by way of discharge communication as to the signs of Mr Cauchi's mental health deterioration, which were evident from at least October 2019.

129. Dr Boros-Lavack gave evidence that Dr Pietsch called her after his consultation with Mr Cauchi. Dr Pietsch did not agree that he had any phone call with Dr Boros-Lavack.

Findings: Whether phone call occurred between Dr Boros-Lavack and Dr Pietsch

130. On balance, I cannot accept that Dr Boros-Lavack did call Dr Pietsch, even though she may genuinely believe she did. There is no primary evidence of a call from Dr Pietsch to Mi-Mind Centre on 13 November 2023 (the day of Mr Cauchi's appointment with Dr Pietsch). There is only primary evidence of a call from Mi-Mind Centre (its reception phone number) to Dr Pietsch's practice on 16 November 2023, and it is not clear whether Dr Boros-Lavack made that call (as opposed to someone else from the Mi-Mind Centre practice). Neither Dr Boros-Lavack nor Dr Pietsch made a note of any call between them.

131. Dr Pietsch gave persuasive oral evidence that it was rare to have a phone call with a psychiatrist, that he would have made a note if it had occurred as described by Dr Boros-Lavack, and that it would not have made sense for him to write a letter to Dr Boros-Lavack after having just spoken to her.

Other evidence of Mr Cauchi's mental health (2020 to 2024)

132. Two of Mr Cauchi's housemates in Brisbane (from 2020 to March 2022) gave evidence which included that: Mr Cauchi could not look after himself or perform basic tasks; he would make banging noises, walk aggressively and thump the floor, and would making screaming noises; and he would have mood swings and suddenly have a "*twitch*" where his body would move uncontrollably, and his head and neck would turn and twist side to side and he would yell "*gibberish*" and appear angry or irritated. One housemate also noted Mr Cauchi appeared to be like a person who had OCD.

133. An examination of Mr Cauchi's phone by investigating police after his death revealed a number of notable internet searches, notes, or other content from at least late 2022. This included notes

indicating planning of a strike or attack, and regarding using a knife in a mall. On 13 April 2024, Mr Cauchi's internet searches included the Columbine perpetrators.

134. The records extracted from Mr Cauchi's mobile phone also indicate that he sought to obtain drugs between December 2023 and April 2024.

Mr Cauchi's mental state on 13 April 2024

135. The expert panel agreed that Mr Cauchi was psychotic on 13 April 2024.

136. Post-mortem toxicological testing for Mr Cauchi returned a positive result for cannabis, and cannabis was also located in his storage locker after his death. The report of expert toxicologist, Professor Alison Jones, suggests Mr Cauchi had been using cannabis "*within days preceding his death*".

137. Professor Nordentoft opined that it is likely Mr Cauchi targeted young girls and women on 13 April 2024, although there can only be speculation about the content of his delusion. The other expert psychiatrists indicated they were not able to come to a clear conclusion regarding Mr Cauchi's motivations on 13 April 2024.

138. In Dr Boros-Lavack's oral evidence during the Inquest, she initially said that she did not believe that Mr Cauchi was experiencing psychosis on 13 April 2024. However, during her oral evidence the following day, Dr Boros-Lavack ultimately withdrew her evidence from the day prior and accepted that Mr Cauchi was likely psychotic on 13 April 2024 (deferring to the opinion of the expert psychiatrist panel).

Findings: Mr Cauchi's mental state on 13 April 2024

139. I accept there is no doubt that Mr Cauchi was suffering an acute exacerbation of his chronic mental illness, schizophrenia, on 13 April 2024. That was agreed upon by all of the expert psychiatrists.

140. In relation to Mr Cauchi's mental state on 13 April 2024, most of the expert psychiatrists opined that cannabis use likely exacerbated Mr Cauchi's psychotic symptoms or may have been a trigger for a relapse of Mr Cauchi's psychosis. In addition, Professor Large and Professor Nielssen commented more generally on risks posed by cannabis use.

141. Professor Nordentoft was the only expert psychiatrist that specifically opined that Mr Cauchi targeted young girls and women on 13 April 2024.

142. As Professor Nordentoft opined, and as Counsel Assisting submitted, one can only speculate as to whether Mr Cauchi was targeting women and as to the content of his delusion and his inner private logic. There is no logical motivation for his actions.

Findings: Dr Boros-Lavack's evidence

143. Dr Boros-Lavack's evidence regarding Mr Cauchi's mental state on 13 April 2024 was extraordinary and shocking. It was also inconsistent with all of the expert opinion. It was surprising to hear such evidence from a psychiatrist, notwithstanding that Dr Boros-Lavack's counsel submitted that Dr Boros-Lavack had not read all of the expert evidence. Furthermore, Dr Boros-Lavack then resiled from the evidence the next day.

144. It is difficult to understand Dr Boros-Lavack's evidence regarding 13 April 2024 and what her motivation was for giving that evidence, other than it being a continuation of her confirmation bias and a desire to maintain her previous position that Mr Cauchi was not suffering from a

relapse or early warning signs of psychosis. I can otherwise only speculate as to Dr Boros-Lavack's reasons for this evidence.

145. Dr Boros-Lavack's confirmation bias had many problematic consequences. Not only did she minimise many of Mr Cauchi's early warning signs, but even when the worst thing had happened - that is, the events on 13 April 2024 – Dr Boros-Lavack still could not accept that Mr Cauchi had relapsed. This was a serious flaw in her judgement.

146. Regardless of the reasons for the evidence, Dr Boros-Lavack's evidence was wholly inappropriate, wrong, and had a traumatising effect on the victims' families.

147. I do not agree with the submission made on behalf of Dr Boros-Lavack that the question should not have been asked of her. It was reasonable for Dr Boros-Lavack to be asked that question, given her knowledge of Mr Cauchi over such a long period of time. It was relevant to hear Dr Boros-Lavack's opinion, given that history, and also to hear her professional opinion as a psychiatrist. Counsel for Dr Boros-Lavack also submitted the question should not have been asked because Dr Boros-Lavack did not have a lot of material before her; however, Dr Boros-Lavack could have accessed that material if she wanted to do so.

Dr Boros-Lavack's general oral evidence

148. I will also address here the manner in which Dr Boros-Lavack gave oral evidence more generally during the Inquest (on 13 and 14 May 2025), as Counsel for the families urged me to make a number of findings in relation to how Dr Boros-Lavack gave evidence and her reliability.

149. I have taken into account the reasons provided by Dr Boros-Lavack (and via submissions on her behalf) as to why she gave evidence in the manner that she did.

150. On the second day of her evidence, Dr Boros-Lavack apologised for being short at times during her first day of oral evidence, and said that occurred because she was suffering from acute pain, on medication, late for her flight, mentally fatigued, and had given evidence for a long period of time.

151. The submissions on behalf of Dr Boros-Lavack also submitted that Dr Boros-Lavack's application to the Court to complete her evidence via AVL and to return to Brisbane overnight to consult with patients who had appointments the next day had been refused, following opposition from counsel for the families, and that Dr Boros-Lavack was unexpectedly required to remain in Sydney overnight (to give evidence in person during her second day of oral evidence). It was also submitted that it is of some significance that Dr Boros-Lavack had never previously given evidence in court.

152. The process of giving evidence would of course have been stressful for Dr Boros-Lavack and she did give evidence for a long period of time.

153. Dr Boros-Lavack's evidence was, at points, confusing and combative. I am unable to say why that was so and whether it was to do with the stress she was under or any other reason. I therefore cannot make a finding as to the reasons for Dr Boros-Lavack's demeanour and the way she conducted herself when she gave oral evidence.

154. However, Dr Boros-Lavack did lack some reflection and was reluctant to accept any criticism of her management of Mr Cauchi. That is a shame, because the overall purpose of an inquest is to learn lessons, which is particularly relevant to Mr Cauchi's care from October 2019 onwards, and the opportunity to learn such lessons may have been missed.

155. I also accept that Dr Boros-Lavack did fail to make appropriate concessions in her oral evidence.

156. Dr Boros-Lavack's failure to make concessions and accept criticism in her oral evidence may have been as a result of confirmation bias and a desire to defend her position that Mr Cauchi had not relapsed, which even extended to the point in time that she gave evidence as a witness during this Inquest. However, I can only speculate as to her motivations. In any case, Dr Boros-Lavack's evidence was unhelpful.

157. The concessions made on behalf of Dr Boros-Lavack via written submissions following the hearing are addressed above.

Relevant policies, guidelines and procedures

158. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) published its "Clinical practice guidelines for management of schizophrenia and related disorders" in 2016, which are no longer in effect. I make the following recommendations.

Recommendations 2, 3 and 4: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

159. ***Recommendation 2:*** *The document entitled "Clinical practice guidelines for management of schizophrenia and related disorders" contains a watermark stating: "This document is more than five years old and is under review".*

160. *Prompt attention should be given to an amendment of the Guidelines on the management of schizophrenia and related disorders.*

161. *That should include the matters as set out in the complete version of this recommendation in the List of Recommendations.*

162. ***Recommendation 3:*** *The RANZCP should draw up and distribute a separate professional practice guideline on "deprescribing" antipsychotic medication, where a patient with schizophrenia declines to remain on medication, or is deliberately deprescribed. Such a guideline should be based on expert opinion and contemporary evidence.*

163. *Such a Guideline should include the matters as set out in the complete version of this recommendation in the List of Recommendations.*

164. ***Recommendation 4:*** *That the RANZCP collaborate with the Royal Australian College of General Practitioners (RACGP) to develop shared care guidelines to optimise the management of patients with chronic schizophrenia, including treatment resistant schizophrenia, and that the RANZCP assume the role of lead organisation in this process.*

165. In September 2023, subsequent to Mr Cauchi's appointments with Dr Sarkar and Dr Parkar, the RANZCP issued its Professional Practice Guideline 23 titled "Firearm risk assessments".

166. In addition, a more general issue raised during the Inquest related to people with schizophrenia having access to firearms. The Australian-based experts generally indicated that a person with treatment-resistant schizophrenia should not have access to firearms.

Recommendation 5: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Commissioner of the NSW Police Force and the Commissioner of the Queensland Police Service

167. ***Recommendation:*** *That the Commissioner of the NSW Police Force and Commissioner of the Queensland Police Service convene with relevant representatives from the RANZCP to form a working group to consider the nature and role (if any) of psychiatrists in preparing assessments of fitness for weapons licensing, and whether that role should be incorporated into weapons licensing legislation (including in the form of a Multi-Disciplinary Assessment Panel or other such panel of experts), including having regard to the following matters:*

    (a) The extent to which RANZCP "Professional Practice Guideline 23 – Firearms Risk Assessment" (2023) provides appropriate guidance for psychiatrists and firearms licensing authorities;

    (b) The extent to which persons with chronic mental health disorders involving psychotic episodes (such as schizophrenia) should be permitted to have any access to firearms; and

    (c) The views expressed in the evidence of the expert psychiatric panel obtained during the Inquest hearing.

168. There was no relevant guideline available regarding the role of a GP when a person with treatment resistant schizophrenia who has ceased clozapine is discharged into their care.

Recommendation 6: To the Royal Australian College of General Practitioners (RACGP)

169. ***Recommendation:*** *That the RACGP collaborate with the RANZCP on the development of shared care guidelines to optimise the management of patients with chronic schizophrenia, including treatment resistant schizophrenia (noting the RANZCP is the lead organisation in this process).*

170. *The Guideline should include the matters as set out in the complete version of this recommendation in the List of Recommendations.*

Mental health context in NSW and QLD

171. Certain broader issues relating to the mental health context in NSW and Queensland were considered in the Inquest, to the extent they arose from considering Mr Cauchi's circumstances.

172. These broader issues included short-term and long-term accommodation options for persons experiencing mental illness (with reference to the housing models provided by Habilis and Haven); co-responder models (in relation to which Recommendation 11 is made in Part 3); outreach services; and care provided by community health centres (CHCs). I make the following recommendations.

Recommendation 7: To the NSW Government

173. ***Recommendation:*** *That the NSW Government:*

    (a) Model the need for short term accommodation in the greater Sydney area for those experiencing mental health issues and homelessness, and then establish and support those services.

(b) Support the establishment and ongoing evaluation of long term accommodation for those experiencing mental health issues and homelessness, with on-site or easily accessible long term mental health care, based on the models delivered by Habilis (NSW) and Haven (Victoria).

Recommendation 8: To the NSW Government

174. ***Recommendation:***

(1) That the NSW Government, over the next 12 months:

(a) Obtain advice from NSW Health on the decline of and related demand for mental health outreach services in NSW, and on the work being done in this area;

(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

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

(2) Having regard to evidence that some patients with treatment resistant schizophrenia are cared for by community health centres (CHCs), and then discharged to general practitioners after episodes of care, the NSW Government, over the next 12 months:

(a) Obtain advice from NSW Health on what is required to provide a model of care for persons suffering complex, severe mental illness, with a risk of relapse;

(b) Obtain from NSW Health a comprehensive report advising of options to improve the current system in which public mental health services are provided to consumers, including:

i. The need for additional resourcing for CHCs;

ii. The need for a better understanding amongst private practitioners as to the treatment and support pathways already available within the NSW Health system that they can draw on;

iii. More constructive engagement in collaborative care between mental health services and the primary care sector; and

iv. A mapped timeframe for achieving those reforms, setting out the steps required to build frameworks and workforce capacity, and

(3) For the assistance of CHCs, NSW Health should ensure clinicians have ready access to contemporary evidence based "deprescribing" guidelines, noting potential risk inherent when consumers, including those with treatment resistant schizophrenia cease prescribed psychotropic medication. In order to facilitate this goal, NSW Health should liaise with

RANZCP in relation to the development of deprescribing Guidelines referred to at Recommendation 3.

Findings: Recommendations made in Part 2

175. As noted by Counsel Assisting, the recommendations that I have decided to make in relation to mental health care are based on the expert evidence in the Inquest and are aimed at practical changes in the healthcare system, to dramatically improve the lives of individuals living with treatment resistant schizophrenia and their families and communities. I echo Counsel Assisting's sentiment that: *"If implemented, those changes would mean that people like [Mr Cauchi] suffering from a chronic condition with a high risk of relapse into psychosis if unmedicated will be less likely to fall through the cracks"*.

176. In making these recommendations I am keeping front of mind the Good, Singleton and Young families' view that "*one of the most important functions*" of this Inquest is to consider "*reforms that are necessary in the funding and in the conduct of the mental health sector in this country*".

177. The Good, Singleton and Young families expressed their gratitude to the experts that have participated in the formulation and reformulation of recommendations in relation to the improvement of the mental health system. I am similarly grateful to the expert psychiatrists and to Dr Wright for their input regarding the recommendations and their support for the relevant recommendations.

178. Dr Wright's statement refers in particular to the need for additional resourcing for CHCs (to enable NSW Health to engage with consumers over a longer term, engage more constructively in collaborative care between mental health services and the primary care sector, and enable better continuity of care for complex patients) and that there is a need for private practitioners to have a better understanding as to the treatment and support pathways already available within the NSW Health system that they can use.

Part 3 Mr Cauchi's interactions with the QPS

179. Mr Cauchi had no criminal history. However, during the period he resided in Queensland, he came to the attention of the QPS on a number of occasions over a period of about 22 years. Those interactions were examined primarily to determine whether there were opportunities to facilitate Mr Cauchi's engagement with mental health services. The interactions with QPS examined during the Inquest are set out below.

180. First, on 9 September 2021 a traffic stop was conducted by S/Cst Roy Avenell, who had observed Mr Cauchi driving erratically.

Findings: Traffic stop

181. S/Cst Avenell's handling of the interaction on 9 September 2021 was appropriate. There were not sufficient grounds for an EEA at this time.

182. Mr Cauchi was stopped by the QPS for erratic driving three times in a 12-month period, the stop by S/Cst Avenell being the third occasion. Had a mental health flag been used on the two prior occasions when Mr Cauchi had been pulled over for erratic driving, this would have captured S/Cst Avenell's immediate attention. This would have most likely led to a different response by the officer.

183. This interaction emphasises the importance of the use of mental health flags. The QPS have taken steps to remind, and further educate, officers about their creation and use. Their proactivity is commended.

184. On about 27 July 2022, a Crime Stoppers report was made regarding Mr Cauchi's persistent contact with an all-girls boarding school. No offences were identified, and Mr Cauchi's conduct was considered to be concerning behaviour. The Toowoomba Intelligence Office made a number of unsuccessful attempts to contact Mr Cauchi before the submission was closed on 28 December 2022.

Findings: Crime Stoppers Report concerning School

185. It was appropriately conceded that with the benefit of hindsight, it would have been better to provide the intelligence report to the district MHIC for additional review and appraisal. The information provided by the School should have raised more concerns. The report warranted a more holistic review and assessment in particular given the mental health flag on QPRIME in relation to Mr Cauchi. It is accepted that it is not possible to know whether a more holistic approach would have triggered further investigation or resulted in Mr Cauchi being diverted into mental health treatment.

186. On 8 January 2023, S/Cst Matthew McDonnell and S/Cst Hope Porter attended the Cauchi family home in response to a report by Mr Cauchi that his father had stolen his knives. Mr Cauchi's parents disclosed to the officers that they had removed the knives from the home as they were concerned about him having access to them when he was mentally unstable. Mr Cauchi's mother told the officers he had pushed his parents and that he was not presently taking medication and his mental health was unmonitored. The officers spoke with Mr Cauchi about respecting his parents and of being of good behaviour towards them. The incident was recorded on QPRIME as "Domestic Violence other action".

187. Upon his return to Toowoomba Police Station, S/Cst McDonnell emailed S/Cst Peter McDiarmid, who was acting in the role of the MHIC, Darling Downs Police District, outlining the interaction at the Cauchi family home and requesting follow up be made with the family and Toowoomba mental health. S/Cst McDiarmid stated he saw the email but inadvertently overlooked making the requested contact. The QPS have subsequently amended their process for referrals to a MHIC with safeguards to prevent referrals inadvertently not being actioned.

Findings: Attendance at the Cauchi family home on 8 January 2023

188. There is no criticism of S/Cst McDonnell and S/Cst Porter for failing to detain and transport Mr Cauchi for an EEA. Their actions were reasonable particularly given the terms of s 157B of the *Public Health* Act 2005 (Qld). It is accepted that even if Mr Cauchi had been transported to hospital for an EEA, it is too speculative to say whether he would have restarted his medication, and his symptoms would have been brought under control.

189. S/Cst McDonnell and S/Cst Porter should not be criticised for not taking out a Police Protection Notice, noting the complexity of the scenario they were faced with.

190. The management of S/Cst McDonnell's email was a missed opportunity which S/Cst McDiarmid and Insp Quinlan both recognised. They each made appropriate concessions. S/Cst McDiarmid is a competent, committed and responsible police officer who overlooked a single email amidst a significant workload and limited resources.

191. Changes have been made in relation to the use of QPRIME to overcome the risk of a task being overlooked in the future.

192. The above interactions were examined in the context of the legislation which provides for the power for QPS officers to detain and transport a person to a care and treatment facility, being s 157B of the *Public Health Act 2005* (Qld). In contrast to NSW and Victoria, s 157B relevantly provides that a person can only be detained and transported if they themselves are at immediate risk of serious harm. Whether there is an immediate risk of serious harm to others is not a consideration. If a police officer detains and transports the person to a health facility, they must immediately make an emergency examination authority (EEA) for the person.

Recommendation 9: To Queensland Health

193. ***Recommendation****: That Queensland Health give consideration to an amendment to s 157B of the Public Health Act 2005 (Qld) to:*

(a) Refer to "immediate risk of serious harm to others", rather than only referring to "immediate risk of serious harm to self";

(b) Expand the example in the provision beyond that of suicide; and

(c) Provide further clarification on the definition of "serious harm" for the purposes of the provision.

194. Relevant also were the supports available to the QPS in dealing with people with mental health concerns which included the Police Communications Centre Mental Health Liaison Service (PCC MHLS) (which facilitates the sharing of information and advice from Queensland Health clinicians to QPS officers responding to situations involving people experiencing mental health issues) and MHICs (QPS officers who provide assistance in the assessment and response to mental health incidents and assist with requests for health information from Queensland Health and Queensland Ambulance).

Recommendation 10: To the Commissioner of the Queensland Police Service

195. ***Recommendation:*** *That the Commissioner of the Queensland Police Service:*

(a) Evaluate the service needs for Mental Health Intervention Coordinators (MHICs) in each region; and

(b) Give consideration to increasing staff in the Darling Downs region, an area of recognised need.

Recommendation 11: To the NSW Government

196. ***Recommendation:*** *That the NSW Government consider options to support the roll-out of appropriate co-responder models so that they are more widely available throughout NSW.*

197. A further issue examined was the grant by the QPS of a Statement of Eligibility to Mr Cauchi on 28 April 2021. A Statement of Eligibility is a necessary condition for membership of an approved pistol shooting club. Dr Sagir Parkar, psychiatrist, provided a medical certificate to Mr Cauchi for the purposes of his application for a Statement of Eligibility. Dr Parkar subsequently advised the QPS that he considered Mr Cauchi to be a fit and proper person to be issued with a weapons licence at that stage.

Findings: Conduct of Dr Parkar

198. Before advising the QPS that Mr Cauchi was a fit and proper person to be issued with a weapons licence at that stage he should have exercised a great deal more caution than he did. Dr Parkar appropriately conceded that he should have exercised greater caution.

Part 4 Mr Cauchi's movements in NSW (2023 – 2024) and his interest in knives

199. Mr Cauchi left Queensland for the final time on 21 December 2023, arriving in Sydney on 22 December 2023. Following his arrival in NSW, it appears that Mr Cauchi spent most of his time in Sydney, although he had also travelled to Newcastle and Wollongong and visited family in Melbourne. During Mr Cauchi's time in Sydney, he was homeless and socially isolated.

200. Mr Cauchi had a single interaction with NSWPF, on 21 July 2023. Officers attended upon Mr Cauchi who was sleeping rough in the Rocks area of the Sydney CBD. Mr Cauchi was searched, and no items of interest were located. No further action was taken.

Findings: Mr Cauchi's interaction with NSWPF on 21 July 2023

201. At the time of the interaction between NSWPF officers and Mr Cauchi on 21 July 2023, he did not pose any danger to himself or the community and consequently, there was no opportunity at that time for Mr Cauchi to be referred to mental health services or for an involuntary admission to be considered.

202. The actions of the NSWPF officers on 21 July 2023 were reasonable. A general search was conducted which found no items of interest. A cutlery set was located in Mr Cauchi's backpack which the officers accepted was for the preparation of food. I find this to be reasonable and appropriate in the circumstances.

203. On 24 August 2023, Mr Cauchi presented to Royal Prince Alfred Hospital (RPAH) for a physical health complaint. There is nothing to suggest that this was an opportunity to engage with Mr Cauchi regarding his mental health.

204. On various occasions between July 2023 and March 2024, Mr Cauchi engaged with organisations that provide services to people experiencing homelessness. Staff at those organisations observed that Mr Cauchi may have had mental health issues but that his behaviour was not unusual or threatening.

205. From at least October 2023 to April 2024, Mr Cauchi hired storage spaces at various Kennards Storage facilities (in the ACT, NSW and QLD) and stored belongings there. Mr Cauchi spent excessive amounts of time on site and left his belongings outside of his storage unit. There were also concerns that Mr Cauchi had been sleeping on site.

206. From 31 January 2024 to 13 April 2024, Mr Cauchi rented a storage locker at Kennards Waterloo. Staff described that Mr Cauchi was quiet and considered, was experiencing some mental health issues, and his behaviour was "*really odd*". Following the events of 13 April 2024, investigating police searched Mr Cauchi's Kennards Waterloo storage locker and located items including: an empty KA-BAR knife box; a four pack of Coles branded steak knives (one knife present, three missing); clear resealable bags containing cannabis; and notes and drawings.

Mr Cauchi's interest in, and purchase of, knives

207. On 13 April 2024, Mr Cauchi used a KA-BAR USMC knife during his attack at WBJ. Whilst designed for utility use during World War II, the knife is also used for camping, hunting and fishing, amongst other uses.

208. Mr Cauchi purchased the knife at a camping store in Western Sydney on 24 February 2024. Mr Cauchi said he was a collector and "*it has to be the right one*". Staff present that day described Mr Cauchi as skinny, not well groomed, constantly smiling, happy, and trying to make jokes (which was different to how he had been when he had called the store the day prior). Mr Cauchi subsequently made enquiries about sharpening the knife, including on 24 March 2024.

209. Mr Cauchi had previously purchased a number of knives. After his death, police seized four KA-BAR USMC knives and one "Azero" knife from the Cauchi family home. It is not known when, or from where, all of these knives were purchased.

210. Evidence obtained from Mr Cauchi's phone showed he had conducted searches relating to KA-BAR knives, military combat and the use of knives, and knife sharpening services.

Police powers with respect to knives

211. In Queensland, under "Jack's Law", QPS officers are empowered to use hand-held metal detectors ("wanding" devices) to detect and seize concealed weapons in certain public places and under certain circumstances, which can include shopping centres.

212. In NSW, Part 4A of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (LEPRA) was introduced in June 2024. Part 4A is based on Jack's Law and introduced a trial of additional powers for police officers, to enable the use of hand-held scanners to carry out scans in relation to knives and other weapons without a warrant in designated areas. WBJ had been the subject of a "designated area" declaration seven times as at 23 December 2025.

Recommendation 12: To the NSW Government

213. ***Recommendation**: That the NSW Government monitor and assess the trial of the amendments to the Law Enforcement Powers and Responsibilities Act 2002 (NSW) in respect of "wanding", including whether:*

    (a) Such trial should be made permanent; or

    (b) The law should apply to certain "crowded places" without the need for a declaration to be made.

Part 5 Active Armed Offender (AAO) events

"Escape. Hide. Tell."

214. As Mr Cauchi's actions on 13 April 2024 fell within the definition of an Active Armed Offender (AAO) incident, the Inquest explored the framework in Australia for AAO events. The current guidance from the Australia-New Zealand Counter Terrorism Committee (ANZCTC) is: "Escape. Hide. Tell.". Evidence in the Inquest suggested this messaging is not well known within the community.

215. The intent of that message is for members of the public in an AAO situation to: Escape from the armed offender (if they can do so safely); Hide somewhere safe (if they cannot escape); and Tell (including by reporting the incident to police on Triple 0 when it is safe to do so).

Findings: "Escape. Hide. Tell."

216. An AAO incident is unlike any other emergency, and it requires a specific message.

217. Unlike the UK messaging, the Australian guidance of "Escape. Hide. Tell." is framed in such a way as to focus on ensuring that in the event of an AAO attack, people move away from danger, are not filming with their phones, and take themselves out of harm's way as swiftly as possible.

218. The recent media release and circulation of the "Escape. Hide. Tell." Materials in October 2025, including updates to make this material more accessible to members of the community, is commended; however, it is necessary and desirable for there to be further promotion and dissemination of this message to the NSW public.

Recommendation 13: To the NSW Government

219. ***Recommendation:*** *That the NSW 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.*

Part 6 The events of 13 April 2024

220. There is extensive CCTV footage depicting Mr Cauchi on 13 April 2024.

221. As at 13 April 2024, Mr Cauchi was homeless and had spent the night near a toilet block at Maroubra Beach. That morning, Mr Cauchi travelled to Kennards Storage, Waterloo, where he took a knife out of his rented storage locker and placed it in and out of the knife sheath and different bags for around 20 minutes, pacing back and forth. Mr Cauchi then travelled to Bondi Junction, although it does not appear he took the knife with him at that stage. Mr Cauchi returned to Kennards Storage, Waterloo (arriving just after 11:00am), and it appears he placed in his backpack the knife he would use later that afternoon at WBJ.

222. Mr Cauchi then travelled to WBJ, and then Bondi Beach, before returning to WBJ and entering WBJ at 2:48pm. Mr Cauchi purchased food and drink from a supermarket and then walked around WBJ in an apparently aimless manner.

223. Just after 3:22pm, Mr Cauchi walked into WBJ for the last time via the Centre Court Entry on Level 4 (Oxford Street level). He was wearing an Australian NRL jersey and shorts, with a black backpack.

Chronology of the attack

224. Mr Cauchi walked through Level 4 of WBJ and at just after 3:31pm, he lined up in a queue of customers at the Sourdough Bakery and Café, directly behind Dawn Singleton. At 3:32pm, Mr Cauchi placed his backpack on the floor. Seconds later, he retrieved a KA-BAR knife from his backpack. At 3:32:55pm, Mr Cauchi stabbed Dawn.

225. Within just under three minutes, Mr Cauchi stabbed a total of sixteen victims, including the six victims who ultimately died from their wounds. The deceased victims are Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Faraz Tahir and Pikria Darchia.

226. Family members, civilian bystanders, and WBJ staff assisted the victims until first responders arrived. Tragically, Dawn, Jade, Yixuan and Pikria died at the scene. Faraz was extricated to the ground level of WBJ where NSWA crews provided further extensive treatment, however he was declared deceased at 4:24pm. Ashlee was declared deceased at 4:29pm shortly after arriving at St Vincent's Hospital.

Inspector Amy Scott's use of force

227. At around 3:35pm on 13 April 2024, NSWPF officer Insp Amy Scott was driving on Bondi Road (to an address in the vicinity of WBJ), when she heard a police radio broadcast regarding "*... multiple calls, multiple stabbings, multiple locations at [WBJ]*". Insp Scott proceeded under lights and sirens to WBJ, arriving at the Oxford Street entrance near Zara at 3:37:15pm. Almost simultaneously, Mr Cauchi began to make his way up the escalator near Zara from Level 4 to Level 5.

228. Mr Damien Guerot and Mr Silas Despreaux approached Insp Scott and walked with her into WBJ (which she entered at 3:37:21pm). They directed Insp Scott to go up the escalators near Zara from Level 4 to Level 5. Insp Scott understood from the information given to her by civilians that there were one or more AAOs. Insp Scott formed the view that she could not wait for colleagues to arrive and had to go into the Centre to try to find the threat. She unclipped her service firearm prior to proceeding up the escalator.

229. Insp Scott saw Mr Cauchi with the knife on Level 5 and yelled to him something similar to "*Stop*". Mr Cauchi turned, looked in her direction, and ran. Insp Scott gave chase, notifying police radio she was in foot pursuit and naming stores she could see. Insp Scott did not draw her firearm immediately and kept it holstered with her hand on it while she ran after Mr Cauchi. Mr Despreaux and Mr Guerot accompanied Insp Scott, running behind her as she pursued Mr Cauchi.

230. Mr Cauchi stopped suddenly, around 10 metres beyond the Eckersley's Art & Craft store. Insp Scott ushered people in the vicinity behind her and into nearby shops and gestured with her hand for a female with a pram ahead of her to move. Insp Scott yelled out "*mate!*" to get Mr Cauchi's attention, which caused him to turn and face her.

231. At 3:38:34pm, Mr Cauchi ran towards Insp Scott holding the knife. At 3:38:40pm, in response to Mr Cauchi running towards her, Insp Scott retreated backwards and drew her firearm, discharging three rounds, two of which struck Mr Cauchi, fatally wounding him, and he fell to the ground. The CCTV footage demonstrates that if Insp Scott had not backed up as she did, Mr Cauchi would have landed on top of her. When asked what was going through her mind at this time, Insp Scott replied: "*That [Mr Cauchi] was going to kill me*".

232. At 3:39:40pm, Insp Scott made a radio broadcast including "*I need Ambos*". At 3:40:48pm, two further police officers arrived at WBJ, and one commenced CPR on Mr Cauchi. NSWA paramedics subsequently assessed Mr Cauchi at the scene. At 3:59pm, Mr Cauchi was formally declared deceased.

233. The view of expert Scott Wilson, and of NSWPF, was that Insp Scott's discharge of her firearm was the only option available to her and was entirely consistent with training and policy.

Findings: Insp Scott's use of force

234. Insp Scott's use of force on 13 April 2024 was entirely justified and appropriate.

235. On that day, Insp Scott attended WBJ rapidly in response to reports of patrons being stabbed; she arrived just over two minutes from when she heard the priority broadcast on police radio.

236. Not long after her arrival, Insp Scott was approached by civilians and became aware of the significant danger posed by Mr Cauchi, that he was stabbing people inside the Centre and people had been seriously injured. As a result of her training, Insp Scott determined to enter WBJ alone and not wait for her colleagues to arrive. This was incredibly brave. Insp Scott was candid in her evidence in that she believed she may not come out of WBJ alive that day.

237. Within one minute and 25 seconds, Insp Scott had entered WBJ, proceeded up to Level 5, pursued Mr Cauchi by foot and confronted him. At this time, Insp Scott and Mr Cauchi were around the Level 5 footbridge near Eckersley's. Insp Scott showed incredible situational awareness, providing direction to those around her, conscious of her surrounds and that she may need to use her arms and appointments, including her firearm.

238. Mr Cauchi turned to face Insp Scott, holding the knife he had used in the attack, and ran towards her. Mr Cauchi's actions were captured entirely on CCTV footage and are consistent with the description provided by Insp Scott in her account of the events of that day.

239. Insp Scott's use of her firearm was consistent with NSWPF policy and procedures, and in circumstances where it is clear from the available footage that Mr Cauchi was advancing towards Insp Scott and about to attack her with a knife.

240. The training Insp Scott had received, in particular the NSWPF AAO training, outlined above, had equipped her to deal with the violent and unpredictable scenario she faced on 13 April 2024.

241. The Court reiterates the sentiments expressed by many parties in the Inquest, who acknowledged Insp Scott's courage and bravery. The Court acknowledges, as Insp Scott has herself, the bravery of the numerous NSWPF officers who attended that day and entered WBJ in the same violent and unpredictable circumstances.

242. It is highly commendable that the AAO training provided by the NSWPF facilitated the rapid response of Insp Scott and other members of the NSWPF that day.

Referral to the Australian Bravery Decorations Council

Findings: Extraordinary courage and bravery on 13 April 2024

243. The Australian Bravery Decorations Council is an independent advisory body that considers nominations for awards and makes recommendations to the Governor-General.

244. Five named individuals displayed extraordinary courage and bravery in confronting Mr Cauchi on 13 April 2024. Their actions are worthy of formal recognition.

Recommendation 14: To the Council for the Australian Bravery Decorations

245. ***Recommendation:*** *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 – namely: Inspector Amy Scott; Ashlee Good; Noel McLaughlin; Damien Guerot; and Silas Despreaux.*

Part 7 The response of security to the events of 13 April 2024

Overview of Scentre (WBJ) security

246. WBJ is owned and operated by Scentre Group (Scentre), which operates 42 Westfield shopping centres in Australia and New Zealand. Those centres reach approximately 90% of the Australian population.

247. WBJ is one of Scentre's largest shopping centres. WBJ contains 350 retail stores and 150 commercial spaces. Approximately 21 million customers visit WBJ annually.

248. While Scentre retains an integral role in respect of the security functions as WBJ (including the development of relevant policies and procedures), the delivery of those functions (including by personnel) are provided by Glad Group (Glad), a specialist security sub-contractor. Scentre engaged Glad to provide security services at WBJ for the period 4 September 2023 to 3 September 2028. This engagement is governed by the terms of a Services Agreement between Scentre and Glad (Services Agreement).

Scentre emergency practices, policies, and procedures

249. Scentre has a suite of documents through which its emergency response and security policies and procedures are implemented at a local level, components of which are customisable to the specific operational characteristics and environment of a given shopping centre.

250. The policies and procedures relevant to the security response on 13 April 2024 include the Emergency Response Procedures document (the Red Book), the Pre-Response Planning document (the Green Book), and the Security Site Orders (Site Orders).

Red Book – AAO Response Plan

251. The Red Book is consistent with Australian Standard A23745-2010 and contains comprehensive response guidelines in the event of major incidents and/or emergencies, including AAO incidents. In the Red Book, and consistent with the ANZCTC Guidelines, an AAO is defined as (emphasis added):

> *An Armed Offender who is actively engaged in killing or attempting to kill people, and who demonstrated their intention to continue to do so while having access to additional potential victims.*

252. As at 13 April 2024, the Red Book contained two "Main Objectives" when responding to an emergency situation, being: 1) Get people to safety; and 2) Get information to police. Those were the core responsibilities of Scentre staff and security subcontractors on 13 April 2024.

253. The Red Book's AAO Response Plan then contained five "Main Assignments" which were to be carried out by security responders in the event of an AAO, namely:

    (a) Notify "000".

    (b) CCTV.

    (c) Public Address (PA) system.

    (d) CMEO (Centre Management Emergency Override).

(e) Liaison with police responders.

254. In addition, the Red Book's AAO Response Plan contained recommended initial actions, including to safely investigate an "*unverified*" report, and "*if confirmed*", to immediately assign personnel to carry out the five main assignments. It also provided specific actions for the Chief Warden, including ensuring the five main assignments are carried out and the "Escape. Hide. Tell." advice is delivered.

255. The CCTV Control Room Operator is tasked with further specific responsibilities in the event of an AAO, including:

(a) Using the CCTV system to substantiate the report and locate any offenders;

(b) Reviewing footage to track an offender; and

(c) Conveying information to the Chief Warden, PA announcer, and police on site (or via Triple 0).

256. The Red Book's AAO Response Plan provided that when confronted by an offender, staff should:

(a) Escape where possible, utilising cover and concealment (including taking others to safety);

(b) Move to a safe haven, or, if unable to escape, utilise confrontation management and de-escalation techniques; and

(c) If in imminent danger (and as a last resort) try to disrupt or incapacitate the offender.

Findings: Scentre emergency practices, policies and procedures

257. In relation to the preparedness of Scentre, as stated by expert, Mr Wilson:

> *Scentre, as an organisation, were aware of the risks faced from an Active Armed Offender within their premises. They had specific comprehensive plans within their Red Book Guidance on how their staff should respond if such an attack took place.*

258. Mr Wilson described the Red Book as "*excellent practice*" and that it was probably one of the best prepared documents he had seen. I accept this evidence.

259. There is no criticism of the policy approach of Scentre to an AAO, and indeed, as indicated by Mr Wilson, they had drawn on worldwide practice and learnings in the content of the Red Book which reflected best practice in the response to an AAO.

Local Security Function at WBJ

Role of security officers

260. Security officers in Australia are principally tasked with observing, reporting, and escalating incidents as they occur. They are not trained to engage with or attempt to detain offenders.

261. In accordance with directives provided by the licensing body, the NSWPF Security Licensing & Enforcement Directorate (SLED), security guards are to ensure the safety and security of premises and individuals within those premises. They are not trained or encouraged to engage in activities beyond their scope or ability.

262. An individual working in the security industry in NSW must have completed the appropriate course at an accredited training provider and hold a current security licence. The licence category of primary relevance with respect to the WBJ personnel present on 13 April 2024 is the Class 1A (Security Officer) licence.

Findings: The role of security officers

263. The role of a security guard is to observe, report, and escalate incidents. Security guards are not trained to engage with offenders.

Security arrangements at WBJ

264. Scentre employ management teams responsible for the operation of their shopping centres. The management team includes persons who have oversight and responsibilities in respect of security functions, including emergency incident management.

265. At WBJ, the Centre Management Team as at 13 April 2024 was comprised as follows:

(a) Centre Manager (CM), Luke Caleo;

(b) Retail Manager (RM), Joseph Gaerlan (on-duty); and

(c) Risk and Security Manager (RSM), Bradley Goldberg.

266. Additionally, relevant Assistant Manager positions as at 13 April 2024 were:

(a) Facilities Coordinator (FC), Tyson Rogers (on-duty); and

(b) Risk and Security Supervisor (RSS), Rahim Zaidi (on-duty).

267. Glad took over the provision of security services at WBJ in around September 2023, following the end of the previous security contract held by SecureCorp. The Services Agreement sets out Glad's responsibilities, including staffing, training, compliance, daily security operations, and use of subcontractors.

268. In the period leading up to Glad taking over security operations at WBJ, a number of experienced security officers employed by SecureCorp were offered the opportunity to transfer their employment to Glad. Many of those staff chose not to transfer and ceased working at WBJ in around September 2023.

269. The result of this was that there was a pressing need for Glad to fill a number of security roles at WBJ from October 2023 onwards. In late 2023, there were discussions between Scentre and Glad in respect of expanding the pool of CCTV Control Room Operators at WBJ. The staffing pressures, including the need to recruit further CCTV Control Room Operators, continued up until March 2024.

270. The Services Agreement provides that Glad may utilise further sub-contracted security officers from "authorised providers" approved by Scentre. The authorised provider for WBJ is Falcon Manpower Solution Pty Ltd (Falkon). Security officers directly employed by Glad are referred to as "core" guards. Subcontracted security officers are referred to as "ad-hoc" guards.

271. Glad's security team and Scentre's Centre Management Team are also assigned emergency roles to be assumed in the event of an emergency incident. Emergency roles include Chief Warden, On-Scene Coordinator, and CCTV Control Room Operator. These roles have functions as set out in the Red Book, Green Book, and Site Orders. At WBJ, the Daily Centre Emergency

Roles (DCER) document establishes which persons are to assume the particular roles should an emergency eventuate during a shift.

272. The management of the Services Agreement is principally achieved through weekly operational meetings, which address security operations at WBJ. Glad kept minutes of these meetings. Generally, Mr Goldberg and Jerry Helg attended all meetings; Mr Zaidi, Cameron Stuart, and Andrew David attended frequently; and other Scentre/Glad personnel attended from time to time.

Findings: Overview of security arrangements at WBJ

273. No significant criticism can be attached to the issues that emerged as a result of the subcontracting model implemented at WBJ. There is no evidence that such matters directly contributed to the issues that emerged in respect of the events of 13 April 2024. Moreso, the issues, when identified, were promptly attended to.

274. In relation to the issue of GLA2 being an employee of an unapproved subcontractor of Falkon, the CEO of Falkon, Mr Manzoor, acknowledged that this should not have occurred and was a mistake. Mr Manzoor further provided details of the steps that Falkon has subsequently taken to ensure such issues do not occur in the future respect with to WBJ. His response was responsible and appropriate.

WBJ security systems

275. WBJ is divided into two Zones, which are divided by Oxford Street, being: Zone A (situated to the north) and Zone B (situated to the south).

276. On 13 April 2024, there were 706 CCTV cameras providing 954 views throughout WBJ (including recording operational spaces).

277. In addition to CCTV (which could be reviewed or viewed live), the specialised systems with emergency functions at WBJ are as follows:

    (a) Fire Control Panel.

    (b) PA system. This enables the Operator to broadcast to one or more areas of the Centre, including to provide instructions to people in those areas. Announcements made over the PA system were in accordance with pre-prepared scripts.

    (c) Emergency Warning and Intercommunication System (EWIS). This enables an alarm tone to be sounded in one or more areas of the Centre (and can be either automatically or manually activated).

    (d) CMEO system. Activation of the CMEO would override 80 visual display units (advertising screens) throughout the retail areas of WBJ and display a uniform pre-programmed emergency message.

278. The PA system is programmed to interpose the EWIS alarm tone, if both are being used simultaneously.

279. The CCTV Control Room is a secure space on Level P4 of Zone B. The CCTV Control Room houses operational equipment including computers and monitors displaying CCTV, a Fire Control Panel (operated via a computer), PA system, EWIS, CMEO system, a telephone, and a radio.

280. The Fire Control Room is a secure room accessible from the CCTV Control Room, however requires navigation of some 100 metres of hallways, stairs, and access points. It houses an

extensive built-in Fire Control Panel, EWIS, PA system, and a sprinkler control system. It also contains a computer, a radio, and telephone system directly connected to Fire Control access points located around the Centre, including the CCTV Control Room.

281. The Centre Management Office (CMO), where Scentre management conduct the day-to-day operation of WBJ, is on "Level 13" of Zone A (which is one floor above Level 6 of the retail levels). In the CMO, CCTV could be viewed and a secondary or mimic EWIS that could be operated (via a computer).

282. It was established that on 13 April 2024, the CMEO panels displayed the "Emergency Evacuation" message rather than the "Armed Offender" message.

283. As at 13 April 2024, the Red Book emphasised in relation to use of the CMEO that (emphasis in original):

> *Authorization to use the system will only be given on confirmation that:*
>
> *An **EVACUATION** is required, or a confirmed **ACTIVE** **ARMED OFFENDER** is present*
>
> *Before activating the system, the user must re confirm authorisation with both the Chief Warden and the EWIS/FIP Controller*

Equipment available to security guards

284. WBJ staff communicate using two-way radios. Some staff use a combination of in-ear radio earpieces and lapel microphones.

285. Security officers are also issued with flash cards which contain an easy-to-read summary of radio call codes, call signs, emergency numbers, and key objectives in the event of an emergency. These cards are attached to a lanyard that is provided to all security officers.

286. As at 13 April 2024, security officers did not wear protective vests of any variety.

287. During the Inquest, information was received concerning a proposal in 2021 at Westfield Tea Tree Plaza (WTTP) (located in Adelaide, South Australia) regarding the potential introduction of stab-resistant vests for security personnel. WTTP is owned and operated by Scentre. Certis Group was the security contractor at the relevant time.

288. The issue of stab-resistant vests was also, in part, the subject of a Security Review Presentation prepared by Emily Hunt of Scentre in around October 2023.

Findings: WBJ security systems

289. The capabilities for CCTV monitoring at WBJ on 13 April 2024 were extensive and appropriate. It is accepted that the purpose of CCTV monitoring at WBJ does not involve live monitoring of CCTV footage and that the CCTV Control Room Operator is not tasked with actively identifying incidents or threats.

290. As at 13 April 2024, there was no written policy or procedure that required the CCTV Control Room at WBJ to be staffed at all times. To its credit, Scentre have acknowledged that lack of clarity and rectified the situation. A policy has now been implemented, specifying that the Control Room is not to be left unoccupied and a sign is now displayed in the room to that effect.

291. The alarms and warning systems installed at WBJ were comprehensive and appropriate.

292. In relation to stab-resistant vests and the issues that arose at WTTP, there is no criticism of Scentre with respect to their approach.

293. As at 13 April 2024, stab-resistant vests were neither required nor commonly deployed. The issue of what, if any, protection stab-resistant vests may have offered security guards on 13 April 2024 was not the subject of any evidence in this Inquest, and whether such vests would have made any difference is not known.

294. The resources and equipment provided to security guards at WBJ on 13 April 2024 was appropriate.

295. All security staff at WBJ are now required to wear stab-resistant vests.

Training of security guards at WBJ

296. Glad is required to ensure that each of its employees and subcontractors maintain compliance with the training matrix contained in the Services Agreement. Core security guards are required to undertake various training and induction programs which include completion of the Terrorism Awareness Module. The training received by "ad-hoc" guards differs from the scope and breadth of training provided to "core" guards employed by Glad.

CCTV Control Room Operator training

297. There is a more extensive training programme in place for security officers who are to take on the role of CCTV Control Room Operator. This reflects the added responsibility and pressure associated with the CCTV Control Room Operator role. The process of selecting candidates for the CCTV Control Room Operator role involves agreement from the Scentre RSM/RSS and Glad's site manager and client service manager.

298. Training for the position of CCTV Control Room Operator involves one-on-one training with another experienced CCTV Control Room Operator. The Control Room Training Checklist requires completion of 21 components of training, on topics including: telephone and radio procedure; EWIS operation and PA announcements; following a person of interest (POI) on CCTV; responding to emergencies; and the CMEO. The training ordinarily took approximately five to six weeks.

299. At the conclusion of training on all components, the checklist would be provided to the RSM or RSS, and the trainee would be assessed. The assessment would include a verbal and a practical component to assess knowledge and skills associated with the CCTV Control Room Operator role. If deemed to have passed the assessment, the RSM or RSS would sign the checklist, thereby approving the candidate to "*commence CCTV Control*" room operation unsupervised.

Findings: Training provided to security guards

300. Whilst there was evidence that there was a shortage of appropriately trained CCTV Control Room Operators in late 2023, there is no evidence that recruitment pressures directly compromised any recruitment or training of staff.

301. Scentre and Glad require security personnel to undergo an extensive training program prior to and during their deployment in Scentre premises. Scentre and Glad have taken proactive steps to remediate any missed opportunities that have been identified.

Training and background of CR1

302. CR1 was the CCTV Control Room Operator at the time of the incident on 13 April 2024.

303. In around late October 2023, CR1 commenced working at WBJ. Prior to that, she had worked in the security industry for approximately four years. On 5 November 2023, CR1 worked her first shift at WBJ. CR1 continued to work as a "retail rover" throughout November and December 2023.

304. CR1 was identified as a potential CCTV Control Room Operator by Glad after she had expressed interest in the role. By 27 December 2023, CR1 had commenced training for that position.

305. On 5 January 2024, a Red Book audit for CR1 was conducted by Mr David, which indicated CR1 was unable to answer questions regarding "*What are the two main objectives?*" and "*What are the five main staff assignments in connection with an active armed offender scenario?*". On 17 January 2024, CR1 had a further Red Book audit and again did not correctly answer the question concerning the two main objectives in an AAO event.

306. On 3 January 2024, it was noted in WBJ's Weekly Operational Minutes (the Minutes): "*[CR1] to go through checklist for [C]ontrol [R]oom training*".

307. On 31 January 2024, Mr David sent an email to Mr Goldberg (copying Shaun Luxford of Glad), attaching a completed Control Room Training Checklist. In that email Mr David said that CR1 was "*signed off by both myself and Lulu [Fatima] and ready to commence a position as Control. There will be things she will only learn if given the opportunity to step into the role, and myself [and] Lulu will be here to provide this feedback*".

308. The Control Room Training Checklist attached to that email does not record CR1's name or her signature anywhere. Where "Name of Trainee" appears at the top of the document, it records "*31-01-24 ANDREW DAVID*". Against all 21 topics: "*31/01/24*" appears in the date column; "*ANDREW*" and "*LULU*" are recorded in the "Trainee signature" column; and the signatures of Mr David and Ms Fatima appear in the "Trainer signature & Comments". Nothing is recorded against "Risk & Security Manager's Comments" nor "Approved to Commence Security Control". As previously stated, the document is unsigned by CR1, including in relation to the acknowledgement that training has been received and understood.

Findings: Control Room Training Checklist

309. The evidence as to how or why the CCTV Control Room Checklist came to have all topics signed off on the same date of 31 January 2024 is entirely unsatisfactory. I am not satisfied that there has been an adequate explanation provided as to why the checklist was signed off on the same date in the way it was, given the evidence is clear that the training did not all occur on that one day.

310. There has also been insufficient explanation as to why that checklist was not signed by CR1.

311. The documentation was clearly less than satisfactory as no witness has been able to clearly say, definitively, what happened to bring about the checklist in the form it was. Whilst Mr Goldberg gave evidence that he believed the original paperwork must have been lost, that is only a matter of speculation as to what may have occurred.

312. At 4:24pm on the same date (31 January 2024), Mr Goldberg replied to Mr Andrew's email, stating: "*[i]f you feel she's ready, I'm happy to test her tomorrow. Let me know. I'm free in the afternoon*".

313. On 8 February 2024, CR1 had her first shift in the CCTV Control Room at WBJ.

314. Mr Goldberg gave evidence that both he and Mr Zaidi assessed CR1 for the purposes of her being able to work as a CCTV Control Room Operator unsupervised. There is no documentary evidence in relation to when these assessments occurred.

Findings: Timing and nature of reviews undertaken to approve CR1 commencing as a Control Room Operator (early 2024)

315. There is no documentary evidence showing when the reviews of CR1 were performed (to approve her commencing as a CCTV Room Control Operator). That in itself is unsatisfactory.

316. Having regard to the evidence, I do not consider that there is clear and cogent evidence as to when the reviews of CR1 by Mr Zaidi and Mr Goldberg occurred, and accordingly, it is not possible to make a finding about when these may have occurred.

317. I do not consider there to be sufficient evidence for me to make a finding that CR1 was assessed for the purpose of becoming a CCTV Room Control Room Operator, and that she successfully completed that assessment, on or before 7 February 2024.

318. I am unable to find when it was that CR1 was reviewed/assessed for the purposes of her approval to work as a CCTV Control Room Operator.

319. From around mid-February 2024 to 10 April 2024, the Minutes record various entries in relation to CR1's performance in her role as the CCTV Control Room Operator. This includes the following:

(a) 21 February 2024 (under "Staff responses" heading): "*[CR1] will need to [do] some more training in control especially during mult[iple] incidents*."

(b) 21 February 2024 (under "Incident reports" heading): "*[N]ot getting better, [CR1] reports need work [l]ots of details missing*."

(c) 13 March 2024 (under "Controllers" heading): "*[CR1] needs further training, Doesnt follow up with further details, constantly [sic] asks to repeat, Labelling photos correctly*."

(d) 13 March 2024 (under "Incident reports" heading): "*[CR1] needs updated training.*"

(e) 24 March 2024 (under "Incident reports" heading): "*Still ongoing issues with [CR1].*"

(f) 27 March 2024 (under "Controllers" heading): "*Ongoing issues with [CR1], Reschedule Full Control room Trainig [sic] again with [CR1].*"

(g) 27 March 2024 (under "Staff responses" heading): "*Code Red Response from [CR1] not handled appropriate*".

(h) 10 April 2024 (under "Controllers" heading): "*Responses from [CR1] too slow Retraining to be rescheduled for [CR1]*".

Findings: Whether CR1 was competent to work in the CCTV Control Room on 13 April 2024 unsupervised

320. CR1 was not competent to be in the CCTV Control Room unsupervised on 13 April 2024. There is clear and cogent evidence before me that CR1 was not equipped to carry out the critical

duties required of the CCTV Control Room Operator on 13 April 2024. The most significant of which is the Minutes, which contemporaneously recorded a series of ongoing concerns about CR1's performance as a CCTV Control Room Operator from February 2024 to 10 April 2024.

321. In addition to the minutes, Mr Goldberg accepted, with the benefit of hindsight, that CR1 should not have been left alone in the CCTV Control Room given the identified issues.

322. Finally, there is the expert evidence of Mr Wilson that CR1 was not fully competent to have been left in the Control Room without supervision.

323. It was submitted on behalf of Scentre and Glad that the overwhelming weight of the evidence of witnesses cannot be dismissed. However, I cannot accept and rely upon the evidence of witnesses who were involved in CR1's training, over what is documented in the Minutes. The Minutes themselves are persuasive. The evidence from witnesses involved in CR1's training, despite best intentions and without any criticism of those witnesses, may be influenced by that involvement (even if not consciously).

324. In relation to the evidence of Mr Goldberg regarding whether CR1 should have been left alone in the CCTV Control Room, I accept that proposition was put to him by Counsel Assisting and he agreed. I accept also, the caveat in his answer, that his agreement was with the benefit of hindsight, and I note the totality of his evidence on this topic. Nevertheless, the question was put to him in a very clear and deliberate way, and he agreed to that proposition.

325. I note that Mr Wilson's assessment of CR1's competence was, in part, informed by an analysis of her performance on 13 April 2024. I do not need to rely on Mr Wilson's views to make the finding that CR1 was not competent to be in the CCTV Control Room unsupervised on 13 April 2024. I am satisfied on the basis of the Minutes and the evidence of Mr Goldberg.

326. This finding is not a personal criticism of CR1. And I accept that CR1 may have been improving prior to 13 April 2024, and that Scentre and/or Glad may have believed CR1 was improving. However, CR1's improvement was not to the level that would have made her competent on 13 April 2024. The last negative comment in the Minutes regarding CR1's competency was from only a few days before the incident, on 10 April 2024. Accordingly, it is hard to accept that the issues had been resolved prior to 13 April 2024.

327. I accept that CR1 being on duty in the CCTV Control Room unsupervised on 13 April 2024 was the result of deliberate managerial decisions made by Scentre and Glad. In placing her in that role on that day they were aware, or should have been aware, that she did not have the skills necessary to respond to the circumstances that arose on 13 April 2024.

328. CR1 had, on two occasions, in January 2024 failed a Red Book audit concerning an AAO scenario conducted by Mr David. Ms Fatima had provided training to CR1 in around late March in relation to certain topics, including enhancing her CCTV skills at the request of Mr Stuart and Mr Helg. And again, the Minutes record that persons in positions of management at Scentre and Glad were discussing concerns in relation to CR1's performance as a CCTV Control Room Operator up until 10 April 2024.

Chronology of WBJ security response on 13 April 2024

329. In relation to the chronology, it is established that the following occurred:

TIME	EVENT
3:32:55pm	Mr Cauchi attacked his first victim (Dawn Singleton)
3:33:33pm	The first radio broadcast relating to the incident was made by GLA2
3:36:03pm	CR1 attempted to call Triple 0
3:36:11pm (approximately)	CR1 called Triple 0 and is connected
3:36:36pm	Mr Zaidi made a repeated radio broadcast: *Code black alpha, someone is on the floor, unconscious, active armed offender, contact blue lights, there are multiple victims*
3:38:33pm	Mr Cauchi was shot by Insp Scott
3:39:45pm (approximately)	The CMEO was activated by CR2 with "EVAC ALL" option selected
3:40:38pm	The EWIS system was activated
3:51:14pm	PA announcements commenced

The initial radio broadcast and identification of an AAO incident by WBJ security staff

330. GLA2 is a security guard who was on duty at WBJ on 13 April 2024. GLA2 was the first security staff member to initiate radio communication to alert the WBJ security team to Mr Cauchi's attack at approximately 3:33:33pm. There was no account available from GLA2 as to the content of her initial radio broadcast nor a recording of that broadcast. The various accounts given of GLA2's radio broadcast were not consistent with respect to the information she conveyed.

Findings: The initial radio broadcast and identification of an AAO incident by WBJ security staff

331. It is not possible for me to make a finding about the content of GLA2's initial broadcast around 3:33:33pm.

332. Whilst it is not possible to say what GLA2 said in her initial broadcast, on the available evidence, I am satisfied that the content of the initial broadcast was insufficient in terms of conveying the necessary information to other security personnel that an AAO attack was taking place. This was conceded by Scentre and Glad.

333. Notwithstanding this, it is acknowledged that at the time of the initial broadcast, noting her direct observations of Mr Cauchi's actions, GLA2 would have been fearful for her life.

Findings: When did staff in the CCTV Control Room become aware of an AAO

334. CR1 attempting to call Triple 0 at 3:36:03pm indicates that it is likely that she understood there was some form of emergency at around that time. It followed a radio broadcast from Mr Zaidi requesting "Blue lights". This does not, however, indicate that the emergency was, at that time, understood to be an AAO.

335. The nature of the emergency was made clear in Mr Zaidi's radio call at 3:36:36pm. Accordingly, CR1 would have understood there was an AAO by 3:36:36pm.

Verification of the AAO

336. There was verification of an AAO at 3:36:36pm via the radio broadcast of Mr Zaidi. This was around three minutes after the initial radio broadcast by GLA2, which occurred at 3:33:33pm.

337. Both Mr Wilson and Mr Yates gave evidence that verification of an AAO is necessary before the emergency responses that are prescribed for an AAO are implemented.

Findings: Verification of the AAO

338. It is accepted that it is necessary to have some form of verification before AAO procedures are implemented.

339. The incident was not verified as an AAO until Mr Zaidi's radio broadcast. At that time, Mr Gaerlan attempted to have the five AAO assignments implemented by security staff.

340. In the period between the initial radio broadcast and verification, Scentre staff were responding in accordance with the generic response guidelines.

341. Had the initial radio broadcast been of a quality to alert the security staff to an AAO, this itself would have constituted verification, as the information would have come from a member of the security staff who had witnessed the incident. Accordingly, the approximately three-minute delay that occurred did so as a result of the need to obtain further information to verify the incident as an AAO, which is what Mr Gaerlan was attempting to do when he proceeded out onto the Centre floor.

342. Mr Yates has committed to reviewing and resolving any uncertainty in the Red Book in relation to the terminology of verification and it is understood that that will, at least in part, clarify that when the initial alert that advises an AAO is occurring is disseminated, and the genesis of the initial alert is the witnessing of an AAO by a member of the security staff (including the CCTV Control Room Operator), there is no need for further investigation by a member of security team before the AAO assignments can be implemented.

Internal WBJ staff communication and communication between WBJ staff and emergency services

Radio communications generally

343. In the event of an AAO, clear and concise communication is imperative. The expert evidence of Mr Wilson was that the "*golden rules of good radio communication are clarity, simplicity, brevity and security*", and that he considered that those golden rules were not adhered to on 13 April 2024.

344. Scentre appropriately conceded that difficulties arose in relation to the radio communication and high traffic volumes. Enhanced training and policy measures have been introduced by Scentre to address this issue.

The Triple 0 call made by CR1

345. CR1 dialled Triple 0 on the CCTV Control Room landline telephone at 3:36:03pm. This call did not connect. CR1 attempted to call Triple 0 again at around 3:36:11pm, which connected. It appears that the call was terminated at 3:42:31pm and that CR1 was on hold for several minutes during that call.

Findings: The Triple 0 call made by CR1

346. The phone call made by CR1 to Triple 0 was below the standard of what might be expected of a person in the position of CCTV Control Room Operator. As Scentre appropriately conceded, with respect to the information conveyed to Triple 0, it should generally be better than information provided by members of the general public. The extremely stressful circumstances in which this call was made are, however, acknowledged.

The response of certain security staff at WBJ to the AAO

Joseph Gaerlan

347. Mr Gaerlan was in the role of Chief Warden on 13 April 2024 and was in the bathroom located outside the CMO at the time of the initial radio broadcast of GLA2. Following receipt of this broadcast Mr Gaerlan proceeded onto the Centre floor. He was on Level 5, Zone A when Mr Zaidi made the radio alert at 3:36:36pm, verifying the AAO. Mr Gaerlan subsequently travelled from the Centre floor to the CCTV Control Room.

Findings: The response of security staff at WBJ to the AAO

Joseph Gaerlan

348. The initial broadcast by GLA2 was not sufficient to identify the nature of the emergency as an AAO. Mr Gaerlan entered onto the shopping centre floor in an attempt to verify the nature of the incident as a result of that not being clear. There is no criticism of him, in the circumstances, for taking that step.

349. There is no criticism of Mr Gaerlan for not advising members of the public, including those at Eckersley's, about what was happening. Mr Gaerlan needed to get to the CCTV Control Room to establish command and control and the CCTV Control Room was where he had the best opportunity to gain further situational awareness.

350. In relation Mr Gaerlan's communications with NSWPF, it is not necessarily the Chief Warden who is required to contact Triple 0 and Mr Gaerlan was aware Mr Zaidi was coordinating with NSWPF. There is no criticism of Mr Gaerlan in relation to this issue.

CR1

351. An issue arose also in relation to the adequacy of the response of CR1 to the AAO event. CR1 was the sole CCTV Control Room Operator on duty in the CCTV Control Room on 13 April 2024. At 3:33:33pm, the time of GLA2's initial radio broadcast, the CCTV Control Room was unoccupied as CR1 had left to use the bathroom. She had not taken her radio with her. She returned at 3:34:01pm.

352. Mr Wilson gave evidence critical of CR1's performance as CCTV Control Room Operator.

Findings: The response of security staff at WBJ to the AAO

CR1

353. The fact that CR1 was not in the CCTV Control Room at the time Mr Cauchi commenced his attacks adversely impacted the timeliness of the response. This was accepted by Mr Yates and Mr Iloski. However, there was no requirement at that time for the CCTV Control Room to be staffed at all times, and it is to be expected that the CCTV Control Room Operator will from time-to-time need to depart the Control Room to use the bathroom.

354. It is accepted that it is not entirely fair to criticise CR1's performance on the day by comparing her actions to those of CR2. CR2 was able to quickly locate Mr Cauchi on the CCTV, however, he did so with the benefit of information which had not been available to CR1. I accept also that much of the criticism of CR1's performance on the day is made with the benefit of hindsight.

355. Nevertheless, with respect to how CR1 performed on 13 April 2024, there were shortcomings. In this respect I note Scentre's submission that "*for the most part, CR1 adequately discharged her functions as a control room operator on 13 April 2024*" (emphasis added).

356. Findings have been made in relation to her call to Triple 0. Mr Gaerlan gave evidence about his frustration with CR1 and her inability to provide him with information he needed to coordinate the response. Concerns about CR1 that had previously been identified, for example, that she was "*too slow*" as noted in the entry in the Minutes on 10 April 2024, and that there were difficulties with her communication, did appear to manifest on 13 April 2024.

The nature and timings of alerts/alarms

357. The timings of the relevant alerts and alarms are set out in the Table above at [329].

358. It was accepted by Mr Yates and Mr Iloski that:

(a) The CMEO should have been activated immediately after Mr Gaerlan communicated this direction.

(b) The first sounding of the EWIS alarm was too slow, and that, rather than sounding from the Fire Control Room, it could have been activated from the CCTV Control Room.

(c) The PA announcements could have been made from the CCTV Control Room rather than the Fire Control Room, and they are the best way to inform people of an AAO.

359. A question arose as to whether the AAO alerts could have been deployed earlier and, if so, whether that may have resulted in a different outcome for any of the victims.

360. GLA2 made her radio broadcast at 3:33:33pm, and Pikria, the last victim to have passed away, was stabbed at 3:34:50pm. Accordingly, for the AAO alerts to have possibly altered the outcome for Pikria (in accordance with the procedure outlined in the Red Book), those alerts would have needed to have been activated within that 77-second window.

361. Scentre engaged Fulcrum Risk Services to prepare a report to investigate the time period in which the most efficient of operators could have activated the CMEO and commenced PA announcements in WBJ as at 13 April 2024.

Findings: The nature and timings of alerts/alarms

362. The only relevant testing of the scenario was carried out by Mr White in the Fulcrum Report. Mr Grahame White's report provided for two possible timeframes (between the initial radio broadcast of GLA2 and completion of the first PA announcement).

    (a) **2 minutes and 21 seconds**: where Mr White read the script he prepared (with the CMEO activated after 1 minute and 41 seconds).

    (b) **2 minutes and 32 seconds**: a Scentre reenactment of Mr White's script including physical activation of all alerts and tones and commencement of PA announcements (with the CMEO activated at 1 minute and 45 seconds).

363. Mr Wilson did not do any formal testing of any scenarios, but he said in oral evidence that "*[y]ou could probably do it in 1 min 32 seconds (92 seconds) if you'd used a generic PA message cause you're only pushing a button*." There were no pre-recorded PA announcements available at WBJ prior to 13 April 2024.

364. Accordingly, it was not realistically possible to inform the public of an active armed offender event by making a PA announcement or activating the CMEO before Mr Cauchi had completed the fatal attacks.

Changes made at WBJ since the events of 13 April 2024

365. Significant changes have been implemented at WBJ. They reflect improvements made by both Scentre and Glad. They include, but are not limited to: amendments to policies and procedures, installation of an automated PA system, creation of a secondary control room in the CMO, and the introduction of stab-resistant vests for security officers.

366. In May 2025, Scentre commenced a trial period of having two CCTV Controllers in the WBJ CCTV Control Room during core trading hours. As of 20 May 2025, the trial had no designated end date.

367. In relation to the issue of the volume of the alarm, which significantly impacted first responders, Standards Australia were notified of this issue and took steps to consider whether any changes to the standard are required.

Findings: Changes made at WBJ since the events of 13 April 2024

368. The extent and breadth of changes made by Scentre and Glad are significant and are demonstrative of organisations focused on continual improvement. I commend both Scentre and Glad for their proactivity and commitment to the safety of their staff and patrons.

369. Scentre is encouraged to give serious consideration to mandating that the CCTV Control Room be staffed with two CCTV Control Room Operators on a permanent basis.

Part 8 The response of the NSWPF to the events of 13 April 2024

NSWPF Command and Control

370. Shortly after the attack commenced, NSWPF received reports from calls to Triple 0 alerting police to the incident. Many officers responded urgently. Their response was guided, at least in

part, by the NSWPF AAO guidelines. In addition, the Australian New Zealand Policing Advisory Agency ICCS Plus (ANZPAA ICCS Plus) directs the NSWPF response to major incidents.

371. Upon receipt of information that Insp Scott had resolved the threat, police turned to providing first aid to the victims and securing the location. Insp Scott was the most senior officer at WBJ and remained in command and control until she was relieved by CI Christopher Whalley who notified NSWPF radio at 4:01pm that he had taken over command.

372. At 4:03pm, a Forward Command Post was established in a loading dock by Sgt 1, and at 4:05pm CI Whalley received information that the incident had been declared a "Level 1 Critical Incident".

373. At 4:07pm, CI Whalley spoke with CI Jason Reimer and discussed next steps including the need to review CCTV that was available within WBJ to confirm the number of offenders involved in the incident. CI Whalley instructed CI Reimer to view the CCTV footage to determine the offender's route and whether there were any other people involved. CI Whalley agreed this was an urgent task.

374. Around this time, Sgt 2 attended the WBJ CCTV Control Room, however was not provided with any information regarding a second offender. Between 4:08pm and 4:20pm, there were reports concerning a possible second offender. At 4:27pm, after reviewing the CCTV footage, CI Reimer confirmed via a radio broadcast on police radio that there was only one offender.

375. At about 4:36pm, with assistance from Scentre staff, the Forward Command Post was relocated to a suite on Level 6 in WBJ. An interagency briefing was held at 5:30pm at this location, with NSWA personnel in attendance. Mr Wilson, in the context of interoperability (Part 10) considered the timing of the interagency briefing was "*far too slow… and should have taken place much quicker*."

Findings: NSWPF Command and Control

376. The NSWPF's response to the scene was commendably rapid. As the Inquest heard, in AAO incidents, time is of the essence. Insp Scott arrived at WBJ within two minutes of the "double beeper" indicating the priority of the job. This swift response undoubtedly saved lives. In addition, CI Whalley swiftly attended and took command, appropriately, from Insp Scott within 20 minutes of the first call to Triple 0 and approximately 15 minutes after Insp Scott fatally wounded Mr Cauchi. The timeliness of the NSWPF's response was exemplary.

377. The command and control aspect of the NSWPF response was dealt with "*reasonably well*". The NSWPF command roles were quickly established, as too was the Forward Command Post. Further, all necessary management roles, including investigation, were put in place and an early command centre was established.

378. However, it took two hours for the first multi-agency tactical command meeting to take place, with senior Ambulance and Scentre Staff. This occurred at 5:30pm. It took too long before an inter-agency meeting took place. Extensive evidence was received as to the importance of interoperability and inter-agency communication, and the benefits of co-location of command centres to support shared situational awareness.

379. There was a missed opportunity with regard to the review of the CCTV footage in the CCTV Control Room. CI Whalley took command at the scene at 4:01pm. CI Reimer attended the CCTV Control Room at 4:22pm, with the outcome of that review at 4:27pm. Notwithstanding that the scene was chaotic and that CI Whalley was required to make many decisions in the initial phase of the response, 20 minutes is too long for the CCTV review task to be completed. This is especially so in circumstances where another NSWPF officer was in the CCTV Control

Room prior to this time, and where confirmation of the number of offenders was critical information to the provision of aid to those in need within WBJ. This missed opportunity did not, however, have an impact on patient outcomes.

380. A 'liaison officer' was not appointed to facilitate communication between NSWPF and the other relevant agencies. This was a shortcoming.

381. CI Whalley's actions in the hours after the incident were appropriate and in accordance with NSWPF policy and procedure.

382. CI Whalley deserves specific recognition for his courageous, calm and decisive leadership in his response to the events of 13 April 2024.

NSWPF first aid response

383. After Mr Cauchi was shot, many NSWPF members began rendering aid to the victims, in line with the NSWPF AAO guidelines.

384. The NSWPF first aid response was considered in detail by emergency expert Dr Mazur, who opined that the treatment provided was appropriate and NSWPF officers acted in accordance with their training and the applicable NSWPF policies whilst providing evidence regarding areas for learning.

Findings: NSWPF First Aid response

385. The NSWPF officers who performed first aid on the victims at WBJ should be commended for their bravery and skill. These officers responded promptly and did their very best to assist those in need in what were traumatic and terrible circumstances.

386. The first aid administered by the NSWPF was appropriate. The officers administering aid generally did so in accordance with their training and the relevant NSWPF policies.

387. Some areas for learning were identified, which include:

    (a) Expert evidence was received that detailed the limited utility of CPR or chest compression in providing aid for victims with penetrating trauma injuries. It is unlikely, in the vast majority of situations, that the CPR performed at WBJ would have improved patient outcomes. This is not intended as a criticism of those who performed chest compressions on victims at the scene.

    (b) The importance of never assuming a single stab wound, and that it is necessary to assess every patient to confirm the number of wounds that they might have. This may require those performing first aid to move or rotate a person.

    (c) The importance of moving patients into free spaces, or to an area that provides 360-degree access, whenever possible. Where this is able to occur, those attending will have more access points from which to administer aid and better oversight of the patient overall.

388. Whilst noting the above, the first aid administered by NSWPF officers was adequate. It is acknowledged that it is difficult for NSWPF officers, who are generally not medically trained, to make clinical decisions in situations such as those faced at WBJ on 13 April 2024.

NSWPF response to reports of a second offender

389. NSWPF received information that suggested more than one offender may be involved in the incident. NSWPF officers are taught to consider the possibility of multiple offenders in an AAO incident, although it is rare for there to be more than one offender and reports of secondary offenders are common. As noted, a review of CCTV footage was undertaken and it was established at 4:27pm that Mr Cauchi was the sole offender.

Findings: the NSWPF response to reports of a second offender

390. Given the size of WBJ, the number of individuals in and around the scene, the varying descriptions of the potential second offender provided, and the volume of traffic on the radio, the NSWPF's response to these reports was, in fact, timely.

391. The fact that there was not a second offender does not mean that the police should not have investigated those reports. Clearly, the inverse response – failing to investigate reports of a second offender where there is in fact a second offender – could have dire and catastrophic outcomes.

392. Notwithstanding the timeliness of the NSWPF response, as set out above, there was a missed opportunity with regard to the review of the CCTV footage. The fact that an officer was located inside the CCTV Control Room at 4:07pm indicates that there was the potential for police to undertake their investigations into the reports of a possible second offender much earlier than they otherwise did. Whilst the missed opportunity did not have an impact on outcomes, it is nonetheless imperative that the actions on the day be considered with the intention of learning from them.

Changes within the NSWPF since the events of 13 April 2024

393. Following the incident, the NSWPF conducted an internal review, which identified issues with the response and opportunities for improvement. The results of the review were shared at a formal debrief on 4 June 2024.

394. NSWPF have since made a number of changes which include: updated mandatory AAO training for all operational police and an equivalent course at the NSWPF Academy, with a focus on establishing command and control, use, storage and transport of first aid equipment, searching for wounds on victims, and tactical emergency casualty care; and, a NSWPF review of the AAO guidelines and steps being taken to provide learnings from this Inquest to the ANZPAA.

Findings: Changes since the events of 13 April 2024

395. NSWPF have taken active steps to consider what can be learnt from the horrific events of 13 April 2024, and the ways in which the processes, policies, and equipment utilised by the NSWPF can be improved.

396. NSWPF are commended for their proactivity, especially with respect to the consideration of further training on issues such as the establishment of command and control at AAO events, the administering of first aid including the need to search victims for potential wounds, and the nature and content of the "go bags" that officers are equipped with and use to provide aid to those in need.

397. The NSWPF debrief process conducted on 4 June 2024 was comprehensive and conscientiously framed with the intention of considering opportunities for future enhancements.

Part 9 The response of NSWA to the events of 13 April 2024

398. By 3:36pm on 13 April 2024, the first NSWA units were assigned to respond to the incident. The first NSWA responder, Insp Simpson (NSWA Forward Commander at WBJ), arrived at 3:42:40pm. The initial crews began rendering first aid to victims shortly thereafter.

399. The NSWA AAO Work Instruction sets out the zones of operation that paramedics can enter according to the risks posed at any given scene – Hot Zone (direct threat, no personnel to enter); Warm Zone (indirect threat, only to be entered by Special Operations Team (SOT) paramedics); and Cold Zone.

400. When Insp Simpson arrived, he understood the scene to be a Hot Zone because he could not be certain, at that time, that there were no other offenders involved. Notwithstanding this, Insp Simpson decided to enter WBJ.

401. At 3:48:59pm, Insp Simpson made a Major Incident declaration over the NSWA radio. He also declared a mass casualty incident, and provided more details about the incident via radio, at 3:49:50pm. A major incident channel (MIC) was established at 3:53pm, with attending paramedics directed to the channel for ongoing updates.

402. In the 45 minutes after Insp Simpson arrived on scene, a number of additional senior NSWA personnel arrived. At 4:25:40pm, the NSWA "command and control" structure was broadcast via radio, providing details of the roles adopted by those senior personnel.

403. At 4:28:42pm, AC Armitage formally declared WBJ to be a Hot Zone. The direction was conveyed via NSWA radio by Insp Bibby. This broadcast also directed NSWA crews to exit WBJ and return to the Casualty Clearing Station. One minute prior to the Hot Zone declaration, at 4:27pm, NSWPF broadcast via the police radio confirming that there was only one offender. This information was not immediately shared with NSWA.

404. Between the initial arrival at WBJ by NSWA and the phasing down of the incident, a large number of people took action in response to the incident. The NSWA response to the incident ultimately included five aeromedical teams (one by air, and four by land), five SOT paramedics, 56 paramedics, 86 Control Centre Staff members (from all four Control Centres), 38 Aeromedical Staff and seven Operational Managers.

Findings: The NSWA response to AAO incidents

405. There was a lack of awareness within NSWA regarding the AAO Work Instruction. This lack of awareness was acknowledged by NSWA, and by institutional witness, DC McKenna. Steps have been taken by NSWA to improve awareness of the policy, including by way of additional training.

406. Insp Simpson technically breached the AAO Work Instruction by entering a Hot Zone. However, in circumstances where he was faced with an unprecedented environment and with knowledge of seriously injured patients located inside WBJ, there is no criticism of his entry into the Centre or the resulting contravention of the AAO Work Instruction.

407. With respect to the adequacy of the relevant policies and procedures, there was scope for revision and amendment of both the NSW Ambulance Major Incident Response Plan (AMPLAN) and the AAO Work Instruction. Consideration of, and amendment to, the AAO Work Instruction has already occurred.

Findings: Nature and timing of NSWA response

408. NSWA's response to the events of 13 April 2024 was comprehensive and timely. Notwithstanding the unprecedented nature of the incident, the response of the agency and the attending personnel was impressive. The extensive and timely response of NSWA is particularly notable in circumstances where there were impediments to that response, including the scale of WBJ and spread of victims throughout it, and the prohibitively loud evacuation alarm.

Findings: Triage and treatment

409. The treatment provided by attending NSWA personnel at WBJ was adequate and appropriate.

410. None of the injuries received by the deceased victims were ultimately survivable, meaning that there was no first aid treatment or intervention that could have been administered by attending paramedics that would have affected the outcome for those who tragically died on 13 April 2024.

411. The absence of triage tags being utilised by initial attending crews contributed to a number of victims being re-triaged, causing some delay in progressing the subsequent triage and treatment of casualties.

412. The absence of a rapid sweep assessment contributed to a lack of situational awareness of the casualties at WBJ. The lack of rapid sweep occurred, in part, due to the complex, large-scale and dynamic nature of the scene. These factors rendered it nearly impossible for Insp Simpson, or any other single individual, to gain situational awareness. However, noting the nature of the environment, there is no criticism of Insp Simpson.

413. It is acknowledged that the desire to do as much as possible for the victims at the scene was a consequence of the attending paramedics' dedication to providing the utmost care to those in need. However, going beyond the expected triage for mass casualty events (that is, beyond only opening the patient's airway and controlling external bleeding) led to delay in the identification and initial treatment of patients yet to be initially triaged.

414. The absence of triage tags, rapid sweep assessment, and strict compliance with the mass casualty triage and triage sieve procedures did not have an impact on patient outcomes.

415. The equipment available to NSWA personnel was, generally, adequate and appropriate, but for the availability of Tranexamic Acid (TXA) for all NSWA paramedics. There is clear utility in providing TXA to all NSWA paramedic crews. NSWA are taking steps to implement this change and distribute TXA to all NSWA vehicles.

416. Compelling evidence was heard as to the potentially very significant benefits associated with the use of the Ten Second Triage Tool (TST). Consideration of the TST is set out further in Part 10.

Recommendation 15: To NSW Ambulance

417. ***Recommendation****: That NSW Ambulance confirm the introduction of Tranexamic acid (TXA) as part of the standard products carried in NSW Ambulance vehicle equipment.*

Findings: NSWA Command and Control

418. There were issues with the "command and control" executed by NSWA on 13 April 2024.

419. Due to a communication breakdown by attending senior ambulance personnel, there was a leadership "vacuum" or "confusion" in the initial period of the incident. Whilst the command and control structure was established, it was delayed at least in part due to the lack of communication and role delineation in the early stages of the developing incident.

420. There was some confusion as to role allocations, which may have led to confusion for attending personnel as to whom they were to receive direction from. To that end, it appears that not all senior NSWA personnel utilised their tabards or "orange vests" to identify themselves. More clearly identified role labels, such as through the use of the tabard system, may have improved communication and structure within the incident.

421. There was an intertwining of some roles on scene at WBJ. This included the role of Forward Commander and Incident Site Supervisor. The intertwining of certain roles demonstrated that there is a disconnect between the roles as stated in the NSW AMPLAN and the practical application of those roles or Action Cards.

422. NSWA are aware of areas for improvement and are taking active steps to consider appropriate amendments to the NSW AMPLAN.

423. There is no criticism of the individual responders. Rather, the command and control issues identified feed into broader systemic issues as to the NSWA command and control structure, and to interagency working.

424. The NSWA paramedics who responded to the incident and the NSWA control centre staff are commended. Each demonstrated courage, skill and commitment to providing aid to those in need. Inspectors Bibby, Saywell and Mitchell are commended for their leadership and initiative, as are AC Armitage and AS Cronan who provided further support and direction on the day. The bravery of these individuals, and the care, and the professionalism demonstrated by all NSWA personnel was exemplary.

425. Insp Simpson warrants particular recognition. He undoubtedly saved lives. Faced with a challenging and frightening environment, he demonstrated great courage, leadership and skill, prioritising the well-being and needs of the victims over the potential risk to himself and his crews.

Findings: NSWA Special Operations Team

426. There are insufficient numbers of SOT paramedics available to be rostered. The potential for a delayed response is ameliorated in circumstances where more SOTs can be better positioned across the state.

427. The Special Operations Unit would benefit from being a standalone unit. NSWA have taken steps to consider transition to a standalone unit, including the recruitment of a project lead for the new structure.

428. Whilst there was a delay in SOT attendance on 13 April 2024, the SOT rostering issues appeared to have had minimal impact on the incident. However, it is noted that if the incident had unfolded over a longer period of time, or in different circumstances, it may have had a more significant effect.

429. There is a need for ready availability of necessary ballistics personal protective equipment (BPPE) to enable SOT paramedics to perform their role. NSWA has taken steps to purchase and distribute additional sets of BPPE, and this process is nearing completion.

430. Early notification to the SOT duty phone per the AAO Work Instruction was missed. The need for early notification has been addressed in the Updated AAO Work Instruction.

Recommendation 17: To NSW Ambulance

431. ***Recommendation:*** *That NSW Ambulance give further and expedited consideration to the status of the 2024 review into the Special Operations Unit (SOU) response capability, including the merits of the SOU operating as a standalone unit and with a view to increasing the capacity for Special Operations Team (SOT) resourcing.*

Findings: Zoning for an AAO Incident

432. The Hot Zone declaration was made in circumstances where AC Armitage was faced with a fast-moving and chaotic environment and where a multitude of factors needed to be considered and weighed in a short period of time. The Hot Zone declaration was reasonable in the circumstances.

433. The Hot Zone declaration did not have any adverse impact on patient outcomes at WBJ on 13 April 2024.

434. The fact that NSWA lacked critical information at the time of the Hot Zone declaration is concerning and gives rise to consideration of the importance of inter-agency communication and interoperability.

435. There was a lack of awareness of the AAO Work Instruction. NSWA are addressing this issue through the introduction of additional training.

436. There was a disconnect between the roles of NSWA and NSWPF in relation to the responsibility for dividing an incident scene into the three zones.

437. Consideration ought to be had to the application of the zoning concept more broadly, including the language used to delineate between zones of safety and risk, and the way in which the zones are determined. The ongoing co-operation of the NSWPF and NSWA in their consideration and consultation on this issue is commended.

Findings: NSWA changes since the events of 13 April 2024

438. The critical analysis by the NSWA of its own systems and processes has clearly had a positive impact on the agency and its operations. Their proactivity is commended.

Recommendation 16: To NSW Ambulance

439. ***Recommendation:*** *That NSW Ambulance's current review of the NSW Ambulance Major Incident Response Plan (NSW AMPLAN) includes consideration of the matters (as highlighted during the evidence received during the Inquest) and as set out in the complete version of this recommendation in the List of Recommendations.*

Part 10 Emergency Services Interoperability

440. Interoperability refers to the extent to which organisations can work together coherently as a matter of routine. In major incidents, joint agency interoperability relates to the ability of emergency services to collaborate to improve responses.

441. NSWPF and NSWA are each guided by their own policy document in respect of their approach to command and control, being the NSWPF ICCS Plus and NSWA AMPLAN, respectively. However,

there is no underlying policy or doctrine that specifies the principles for emergency services inter-agency working.

The "Hot Zone issue"

442. The nature and efficacy of emergency services interoperability was explored in the context of the "Hot Zone issue" that emerged in this Inquest.

443. At around 4:28pm, AC Armitage of NSWA directed that WBJ would be declared a Hot Zone in circumstances where there were concerns of a potential second offender. However, a minute prior at 4:27pm, CI Reimer of the NSWPF had broadcast over police radio confirmation of only one offender based on his review of CCTV footage in the CCTV Control Room. Thus, critical information was not conveyed by NSWPF to NSWA. The consequence was that NSWA proceeded on an erroneous basis to evacuate all paramedics from WBJ. The Hot Zone declaration was not downgraded, and paramedics (other than those with the PORS team clearing WBJ) never re-entered the Centre.

Findings: Interoperability – "Hot Zone" issue

444. The "Hot Zone issue" is appropriately characterised as a "near miss". The Hot Zone declaration did not have any adverse impact on patient outcomes. Nevertheless, it was fortunate that no victims remained within the Centre at the time the declaration was made.

445. The fact that the NSWPF held critical information confirming that there was one offender only one minute prior to AC Armitage making the declaration demonstrates the importance of inter-agency communication and the need for a framework which promotes and directs interoperability.

446. While there were instances of interagency working on 13 April 2024, the incident at WBJ made clear that there is a lack of coherent underlying doctrine and a clear framework for interoperability as between NSWA and the NSWPF. A joint model of working, and the application of JESIP or JESIP-like principles, could have mitigated this "Hot Zone issue".

JESIP

447. The Joint Emergency Services Interoperability Programme (JESIP) emerged in the UK following findings from several reviews of major national emergencies and disasters. The JESIP principles for joint working provide structure to multi-agency responses, improving operability between organisations at all levels of control.

448. The five key principles of JESIP are:

(a) Co-locate with other responders as soon as practicably possible at a single, safe, and easily identified location.

(b) Communicate using language that is clear, and free from technical jargon and abbreviations.

(c) Co-ordinate by agreeing on the lead organisation. Identify priorities, resources, capabilities and limitations for an effective response, including the timing of further meetings.

(d) Jointly understand risk by sharing information about the likelihood and potential impact of threats and hazards, to agree on appropriate control measures.

(e) Establish shared situational awareness by using METHANE and the Joint Decision Model.

Findings: JESIP

449. There is a lack of a coherent underlying doctrine or a clear framework for interoperability as between NSWPF and NSWA.

450. JESIP is a well-established framework that has evolved into a well-considered program and framework for interoperability.

451. There is value in considering and implementing JESIP, or a JESIP-like framework in NSW. Furthermore, there is some urgency in considering its implementation.

Recommendation 18: To the NSW Government

452. ***Recommendation***: *That the NSW Government (in consultation with the Commissioners of the NSW Police Force, NSW Ambulance, and Fire and Rescue NSW and other emergency services agencies as appropriate) convene an urgent working group involving relevant representatives from emergency services to consider a) development, and b) implementation, of an emergency services interoperability philosophy, model and framework for NSW (including drawing on the evidence from the Inquest and from the Joint Emergency Services Interoperability Programme (JESIP) framework and doctrine in the United Kingdom, as appropriate) to provide a clear structure and framework for multiagency responses to major incidents.*

Ten Second Triage tool (TST)

453. The Ten Second Triage (TST) was described by Dr Cowburn as a "*novel triage tool designed to be used at any large-scale incident where patient numbers exceed the ability to deliver standard care.*"

454. The TST was developed as a result of a working group created by the National Health Service England to review and reconsider the approach to major incident triage.

455. The TST is focused on the rapid prioritisation of patients and the delivery of immediate life-saving interventions during a major incident rather than absolute accuracy of triage in circumstances where the cognitive load on responders delivering care is very high. This is achieved by removing physiological variables, such as the rate of breathing or a pulse, and using the easily assessable variables of walking, talking and breathing.

456. It is designed so that any responder who is in the environment of the incident can use the tool to deliver care.

457. In 2024, the TST was rolled out to all emergency services in the United Kingdom, including search and rescue organisations and voluntary aid societies.

Findings: Ten Second Triage Tool

458. The TST brings with it significant benefits in a patient-centred multiagency response and interoperability model. The TST can be used by any emergency responder and can reduce initial triage time to approximately 10 seconds. Utilising the tool enables emergency responders to follow clear steps, which are relatively uncomplicated, in order to expedite the provision of life-saving treatment to those in need.

459. The importance and significance of the TST tool cannot be overstated and NSWA should consider its implementation. The implementation should be considered by all emergency

services. Moreover, there is some urgency in its implementation, noting the potential good it could bring to the multiagency response at major incidents.

Recommendation 19: To the NSW Government

460. ***Recommendation***: *That the working group urgently convened by the NSW Government (per Recommendation 18), consider the implementation of the Ten Second Triage (TST) rapid screening tool by emergency services in NSW, including having regard to the expert evidence from the Inquest as to a) the significant benefits that may flow from use of the tool, and b) the need for utilisation of the tool within a broader model of emergency service interoperability (as referred to in Recommendation 18).*

Interagency radio communications as between NSWPF and NSWA

461. The nature and extent of interagency communications – including via radio – was explored during the Inquest. Evidence emerged in terms of certain shared communications streams between NSWA and NSWPF, including, among others, the facility for interagency communication regarding an incident through ICEMS. A factor that seemingly contributed to the delay in information sharing about the Hot Zone issue on 13 April 2024 was the lack of an inter-agency radio channel or other communication protocol.

462. The expert report of Dr Cowburn outlined the UK's shared radio communications, through which all emergency services use the same radio communication system. The expert conclave of Dr Cowburn, Dr Evens and Dr Mazur agreed that a shared major incident channel would be valuable provided it did not overload commanders - a risk that may be mitigated by attaching a communications officer to the Commander (where resources allow). It was also noted that NSWA responders at WBJ were not automatically pushed onto the Major Incident Channel (MIC), resulting in some staff not being aware of information.

463. NSWA witnesses DC McKenna and AC Armitage stated that NSWA are open to exploring the viability of an inter-agency channel for major incidents, as well as interagency talk groups. Although, they identified potential limitations, including information overload, differences in terminology between agencies, and that each agency may have a different operational focus.

464. AC McKenna (NSWPF) similarly acknowledged the difficulties associated with placing all responding emergency services personnel on the same MIC. He accepted that interagency talk groups are, "*in principle*", a "*possibility*", though noted that interagency communication happens to a degree already, given that NSWPF and NSWA operators can use their phones to exchange information.

Findings: Interagency radio communications as between NSWPF and NSWA

465. There are some potential limitations to the use of a single inter-agency radio channel for major incidents, and the evidence does not support the introduction of one.

466. Notwithstanding these issues, there is a clear need for frequent radio communications between the NSWPF and NSWA Control Rooms during major incidents as a means of sharing critical information and achieving shared situational awareness.

467. Evidence was received from Dr Cowburn as to the value of multiagency interoperable talk groups utilised in the UK, and the correlation between the JESIP Doctrine and the promotion of shared situational awareness achieved via communication between Control Rooms.

468. Shared situational awareness can facilitate a more efficient and effective co-response from the attending emergency services. The impact of an absence of communication between the NSWA and NSWPF Control Rooms was clearly demonstrated by the lack of shared situational awareness regarding the number of offenders at WBJ, and there is merit in considering improvements to interagency radio communications.

Recommendation 20: To the NSW Police Force and NSW Ambulance

469. ***Recommendation:*** *That NSW Police Force and NSW Ambulance conduct a joint review of existing interagency radio communication protocols and processes in relation to major incidents, to identify potential areas for enhancement or improvement (including having regard to the principles identified in the JESIP Doctrine regarding communications between Control Rooms), by way of developing or improving joint operating protocols.*

Joint Rescue Task Force

470. Arising from consideration of the nature and timing of the SOT response at WBJ on 13 April 2024 was the suggestion of a "Rescue Task Force".

471. In this regard, S/Sgt Watt (NSWPF) referred to a 2020 training demonstration designed to demonstrate the Rescue Task Force concept. During that demonstration, a joint team consisting of police officers and paramedics was used. In an "indirect threat" scenario it was observed that casualties were located much faster than when extraction was undertaken by police alone.

472. S/Sgt Watt gave evidence that the Rescue Task Force concept was "*effectively*" what Insp Simpson implemented on 13 April 2024 by utilising police to protect him. He agreed that it would "*absolutely*" be better to put more structure around that concept, and that training police on this approach would be "*relatively simple*".

473. DC McKenna (NSWA) stated that while the concept of a Rescue Task Force is something that NSWA is "*open to look at*", it has not been an area the agency had substantially explored. He agreed that consideration of the concept is connected to the NSWA policies regarding zoning.

474. When asked for his views regarding the concept of a Rescue Task Force, AC McKenna (NSWPF) stated that it was "*more for the ambulance to consider*" and that implementation would depend on joint training between NSWPF and NSWA.

475. The expert conclave of Dr Cowburn, Dr Evens and Dr Mazur agreed that "*there is an active role for police in enabling clinical staff to access patients, commensurate to the threat and that police presence can mitigate threats*". However, the experts didn't collectively support the view that a Rescue Task Force was a necessary response to the incident on 13 April 2024.

Findings: Joint Rescue Task Force

476. The Rescue Task Force concept has the clear potential to enable rapid extrication of patients from a scene and provide a means to deliver potentially life-saving treatment in a more expedient manner.

477. Accordingly, I find that there is value in considering the utility of a Rescue Task Force being implemented in NSW.

Recommendation 21: To NSW Ambulance

478. ***Recommendation:*** *That the Commissioner of NSW Ambulance (in consultation with relevant personnel from the NSW Police Force) review the potential utility of a Rescue Task Force*

concept, including having regard to models utilised in other jurisdictions, to consider the feasibility of such a model for NSW Ambulance.

Part 11 Media reporting

479. Part 11 considers the impact of media reporting regarding the events on 13 April 2024, including the broadcasting of footage or images of Mr Cauchi in WBJ with the knife and of victims in situ or receiving aid. There was also evidence of inaccurate and sensationalised reporting. In addition, there were instances of intrusive behaviour and other upsetting conduct by media personnel after 13 April 2024.

480. These issues were a matter of significant concern to some of the families and friends of the deceased, and they described that the reporting compounded their distress.

481. The evidence on these issues was received by the Court in a de-identified form, meaning that no media outlets or journalists were expressly identified.

Findings: Impact of media reporting on the families

482. As Counsel Assisting observed, the nature of some of the reporting and media conduct subsequent to the events of 13 April 2024 does not seem to be in keeping with the Media, Entertainment and Arts Alliance (MEAA) Code of Ethics or the Australian Press Council (APC) Statement of Principles, however this Inquest is not the appropriate forum to determine those matters.

483. Nevertheless, it is clear that some of the media reporting, and conduct of the media, has had a profound effect on the families. Those families were already traumatised by the events of 13 April 2024, and it would seem, in some cases, they were retraumatised by the manner in which some of the media reporting was conducted. Every effort was made during the Inquest to make it clear to the media that the families had been affected by aspects of the reporting of the incident and what had happened subsequent to that. This made it even more important that, during the Inquest, the media remained mindful of the manner in which they reported on the Inquest, and for the most part, the media did seem to comply with what was asked of them from the first day.

484. An exception to that is that in the course of the Inquest, the Court was informed that a media outlet had not adhered to a non-publication order made by this Court in relation to the identities of particular QPS officers. As was submitted on behalf of the relevant QPS officers, these witnesses were, as a result, subject to "*unnecessary, unreasonable, [and] sensational reporting*."

485. In addition, I acknowledge the distress experienced by the families when seeing content obtained from their loved ones' social media published in connection with reporting on this incident, and I continue to encourage the media to be sensitive to the impact of reporting on victims' families.

Finding: Media guideline regarding reporting of mass casualty events

486. Having regard to the evidence concerning the experiences of the families, and in circumstances where a mass casualty event is likely to attract significant public interest, media coverage, and widespread grief, I consider that it would be beneficial for there to be a specific media guideline, or more specific guidance, in relation to the reporting of mass casualty events.

Recommendation 22: To the Australian Press Council

487. ***Recommendation:*** *That the Australian Press Council consider developing an advisory guideline to apply to the reporting of mass casualty incidents. The 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 reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.*

Recommendation 23: To the Australian Communications and Media Authority

488. ***Recommendation:*** *That the Australian Communications and Media Authority engage in consultation with the relevant broadcasting industry representatives to consider whether their Code(s) of Practice should be amended to expressly include provisions that govern the reporting of mass casualty incidents. The Code(s) of Practice 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 reporting (including graphic/inaccurate reporting) may have on a) victims; b) families/friends of any deceased; and c) members of the wider community who may be impacted by such incidents. Regard should be had to the Independent Press Standards Organisation (IPSO), "Guidance on reporting major incidents", United Kingdom.*

Section 81 findings

Section 81 findings regarding the victims

489. In terms of the identity of each of the victims, their date and place of death, and their cause and manner of death, I make the following findings per s 81 of the Act.

Dawn Singleton

490. **The identity of the deceased**
The person who died was Dawn Grace Singleton

Date of death
Dawn died on 13 April 2024

Place of death
Dawn died at Level 4, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Dawn died as a result of stab wounds

Manner of death
Dawn died as a result of injuries inflicted by Joel Cauchi, who attacked her with a knife while suffering a psychotic relapse of his chronic schizophrenia

Jade Andrea Young

491. **The identity of the deceased**
The person who died was Jade Andrea Young

Date of death
Jade died on 13 April 2024

Place of death
Jade died at Level 4, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Jade died as a result of a stab wound to the back penetrating the chest

Manner of death
Jade died as a result of injuries inflicted by Joel Cauchi, who attacked her with a knife while suffering a psychotic relapse of his chronic schizophrenia

Yixuan Cheng

492. **The identity of the deceased**
The person who died was Yixuan Cheng

Date of death
Yixuan died on 13 April 2024

Place of death
Yixuan died at Level 4, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Yixuan died as a result of a stab wound to the central chest structures

Manner of death
Yixuan died as a result of injuries inflicted by Joel Cauchi, who attacked her with a knife while suffering a psychotic relapse of his chronic schizophrenia

Ashlee Kate Good

493. **The identity of the deceased**
The person who died was Ashlee Kate Good

Date of death
Ashlee died on 13 April 2024

Place of death
Ashlee died at St Vincent's Hospital, 390 Victoria Street, Darlinghurst, NSW 2010

Cause of death
Ashlee died as a result of stab wounds

Manner of death
Ashlee died as a result of injuries inflicted by Joel Cauchi, who attacked her with a knife while suffering a psychotic relapse of his chronic schizophrenia

Faraz Ahmad Tahir

494. **The identity of the deceased**
The person who died was Faraz Ahmad Tahir

Date of death
Faraz died on 13 April 2024

Place of death
Faraz died at Level 3, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Faraz died as a result of a stab wound to the abdomen

Manner of death
Faraz died as a result of injuries inflicted by Joel Cauchi, who attacked him with a knife while suffering a psychotic relapse of his chronic schizophrenia

Pikria Darchia

495. **The identity of the deceased**
The person who died was Pikria Darchia

Date of death
Pikria died on 13 April 2024

Place of death
Pikria died at Level 4, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Pikria died as a result of stab wounds

Manner of death
Pikria died as a result of injuries inflicted by Joel Cauchi, who attacked her with a knife while suffering a psychotic relapse of his chronic schizophrenia

Section 81 findings regarding Mr Cauchi

496. I make the following findings per s. 81 of the Act in relation to Mr Cauchi.

Joel Cauchi

497. **The identity of the deceased**
The person who died was Joel Andrew Cauchi

Date of death
Mr Cauchi died on 13 April 2024

Place of death
Mr Cauchi died at Level 5, Westfield Bondi Junction, 500 Oxford Street, Bondi Junction, NSW 2022

Cause of death
Mr Cauchi died due to gunshot wounds involving the neck and chest

Manner of death
Mr Cauchi was fatally and lawfully shot by Inspector Amy Scott, an officer of the NSW Police Force during a police operation