



Coroners Court of New South Wales

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

Volume One



Findings of Magistrate Teresa O'Sullivan
New South Wales State Coroner
5 February 2026

State Coroner of New South Wales

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

Findings and Recommendations

5 February 2026

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List of Abbreviations

AAO	Active Armed Offender
AAO Guidelines	Active Armed Offender Response Guidelines (NSW Police Force)
AAO Work Instruction	Work Instruction WI2023-095 (NSW Ambulance)
AC	Assistant Commissioner
AMPLAN	NSW Ambulance Major Incident Response Plan
ANZCTC	Australia New Zealand Counter Terrorism Committee
ANZCTC Guidelines	Australia New Zealand Counter Terrorism Committee Active Armed Offender Guidelines for Crowded Places
ANZPAA	Australia New Zealand Policing Advisory Agency
ANZPAA ICCS Plus	Australia New Zealand Policing Advisory Agency ICC Plus Policy: A Common Approach to Incident Management
AS	Australian Standard
APC	Australian Press Council
BPPE	Ballistics Personal Protective Equipment
BSA	<i>Broadcasting Services Act 1992 (Cth)</i>
CAD	Computer Aided Dispatch
CCP	Critical Care Paramedic
CCTV	Closed-Circuit Television
CET	Commissioner's Executive Team
CEW	Conducted Electrical Weapon (Taser)
CI	Chief Inspector
CMEO	Central Management Emergency Override
CMO	Centre Management Office
CPSC	Crowded Places Sub Committee
CT	Counter Terrorism
CX	Customer Experience

DC	Deputy Commissioner
DCI	Detective Chief Inspector
DCER	Daily Centre Emergency Roles
DI	Detective Inspector
DSC	Detective Senior Constable
DOM	Duty Operational Manager
EEA	Emergency Examination Authority
EMU	Emergency Management Unit
EOC	Emergency Operations Centre
EWIS	Emergency Warning and Intercommunication System
FCP	Forward Command Post
FCR	Fire Control Room
Green Book	Pre-Emergency Planning (Scentre Group)
ICEMS	Inter-CAD Emergency Messaging System
ICP	Intensive Care Paramedic
IMT	Incident Management Teams
Insp	Inspector
IMT	Incident Management Team
JESIP	Joint Emergency Services Interoperability Principles
LEPRA	<i>Law Enforcement Powers and Responsibilities Act 2002 (NSW)</i>
MCPD	Mandatory Clinical Professional Development
MEEA	Media, Entertainment and Arts Alliance
MHIC	Mental Health Intervention Coordinator(s)
MIC	Major Incident Channel
MTA	Marauding Terrorist Attack

MTA JOPS	Marauding Terrorist Joint Operating Principles
NARU	UK National Ambulance Resilience Unit
NHS	National Health Service England
NSWA	New South Wales Ambulance
NSW AMPLAN	NSW Ambulance Major Incident Response Plan
NSWPF	New South Wales Police Force
OSI	Operational Safety Instructor
OSTG	Operational Safety Training and Governance
PAC	Police Area Command
POI	Person of Interest
PORS	Public Order and Riot Squad
QPS	Queensland Police Service
Red Book	Emergency Policies and Procedures (Scentre Group)
RSM	Risk and Security Manager
RSS	Risk and Security Supervisor
SCCA	Shopping Centre Council of Australia
SCO	Security Control Office
SCR	Security Control Room
SITREP	Situational Report
SOT	Special Operations Team
SOU	Special Operations Unit
S/Sgt	Senior Sergeant
Supt	Superintendent
TECC	Tactical Emergency Casualty Care
TIMS	Telstra Integrated Messaging System

TOU	Tactical Operations Unit
TPU	Terrorism Protection Unit
TST	Ten Second Triage Tool
WBJ	Westfield Bondi Junction
WTTP	Westfield Tea Tree Plaza

Executive Summary

Executive Summary

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 Cauchi'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 managing [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 ("wandering" 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 "wandering", 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 NSW 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. NSW 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 CMO 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 CMO 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 (WTPP) (located in Adelaide, South Australia) regarding the potential introduction of stab-resistant vests for security personnel. WTPP 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 WTPP, 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 CMEQ. 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 multiple incidents."*
- (b) 21 February 2024 (under "Incident reports" heading): *"[N]ot getting better, [CR1] reports need work [lots 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: <i>Code black alpha, someone is on the floor, unconscious, active armed offender, contact blue lights, there are multiple victims</i>
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 CME0 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 CME0 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 CME0 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 CME0 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 CME0 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 NSW to the events of 13 April 2024

398. By 3:36pm on 13 April 2024, the first NSW units were assigned to respond to the incident. The first NSW responder, Insp Simpson (NSW Forward Commander at WBJ), arrived at 3:42:40pm. The initial crews began rendering first aid to victims shortly thereafter.
399. The NSW 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 NSW 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 NSW personnel arrived. At 4:25:40pm, the NSW “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 NSW radio by Insp Bibby. This broadcast also directed NSW 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 NSW.
404. Between the initial arrival at WBJ by NSW and the phasing down of the incident, a large number of people took action in response to the incident. The NSW 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 NSW response to AAO incidents

405. There was a lack of awareness within NSW regarding the AAO Work Instruction. This lack of awareness was acknowledged by NSW, and by institutional witness, DC McKenna. Steps have been taken by NSW 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 NSW response

408. NSW'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 NSW 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 NSW 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 NSW personnel was, generally, adequate and appropriate, but for the availability of Tranexamic Acid (TXA) for all NSW paramedics. There is clear utility in providing TXA to all NSW paramedic crews. NSW are taking steps to implement this change and distribute TXA to all NSW 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: NSW Command and Control

418. There were issues with the "command and control" executed by NSW 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 NSW 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. NSW 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 NSW command and control structure, and to interagency working.
424. The NSW paramedics who responded to the incident and the NSW 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 NSW 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: NSW 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. NSW 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. NSW 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 NSW 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 NSW. The consequence was that NSW 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 NSW 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 NSW.
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 NSW 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 NSW 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 NSW 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 NSW 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 NSW.

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

Part 1

Bondi Junction Inquest: Overview

A. Introduction and context

The events of 13 April 2024

- 1.1 On the afternoon of Saturday 13 April 2024, Joel Cauchi entered Westfield Bondi Junction (**WBJ**) shopping centre in the Eastern Suburbs of Sydney. Just after 3:30pm, Mr Cauchi, armed with a 30 centimetre hunting knife carried in his backpack, began stabbing patrons within the shopping centre.
- 1.2 In just under three minutes, Mr Cauchi moved through three levels of WBJ, stabbing a total of 16 people, six of whom tragically died as a result of their injuries.
- 1.3 The threat posed by Mr Cauchi, and the widespread trauma that resulted from his actions, was, at that time, unprecedented in New South Wales.
- 1.4 Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Faraz Tahir and Pikria Darchia died that day. It is important at the outset to acknowledge them and the unimaginable pain and loss endured by their families. There are no words that can adequately express the devastation that has resulted from the loss of their loved ones in such tragic circumstances. I offer my heartfelt condolences.
- 1.5 I also acknowledge the victims who survived their injuries. The events of 13 April 2024 have had a profound impact on the wider community, whose outpouring of grief was marked in its immediacy and volume.
- 1.6 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.
- 1.7 NSWPF officers attended WBJ that day and commenced a coronial investigation into the circumstances of Mr Cauchi's actions and the response of relevant agencies and organisations to the events that unfolded.
- 1.8 These findings provide a summary of the evidence arising from this investigation and the evidence at the Inquest held between April and May 2025 at the Coroners Court of NSW, and record my findings as required by the *Coroners Act 2009* (NSW) (**the Act**) and the recommendations that I have made pursuant to section 82 of the Act.
- 1.9 The Court received extensive submissions from Counsel Assisting and the interested parties to the Inquest, with the effect that a clear factual chronology of the events of 13 April 2024 emerged. It is acknowledged that for uncontroversial matters, these findings draw largely on summaries of the evidence set out in the submissions of Counsel Assisting.

The victims

- 1.10 At the centre of this Inquest were the six victims who lost their lives on 13 April 2024.
- 1.11 Without meaning any disrespect, they will be referred to by their first names in these findings. It is acknowledged that regardless of the outcome of the Inquest and the delivery of these findings, the deaths of Dawn, Jade, Yixuan, Ashlee, Faraz and Pikria have forever altered the lives of their families in the most profound and devastating way.
- 1.12 The Court is immensely grateful to the families of Dawn, Jade, Yixuan, Ashlee, Faraz and Pikria for their engagement in the Inquest proceedings.

Dawn Singleton

- 1.13 Dawn Grace Singleton, born on 21 May 1998 (age 25), was the first victim.
- 1.14 Dawn was engaged to marry Ashley Wildey. She had a close and loving relationship with her mother, Julie, and her siblings.
- 1.15 Dawn was the cherished daughter of John Singleton.
- 1.16 The Court was grateful for the presence and participation of Julie Singleton and Ashley Wildey in the proceedings.
- 1.17 The loss of Dawn, when she was soon to be married and in the prime of her life is an inconceivable tragedy. I extend my sincere and respectful condolences to her fiancé Ashley, Julie Singleton, John Singleton, her siblings, and all of Dawn's extended family and friends.

Jade Young

- 1.18 Jade Andrea Young, born on 18 February 1977 (age 47), was the second victim. Jade was an accomplished and talented architect. She was married to her husband, Noel McLaughlin, with whom she had two daughters. She was shopping with one of her daughters on the 13th of April.
- 1.19 Jade is survived by her parents, Elizabeth and Ivan, and her brother, Peter. I acknowledge the presence of Noel McLaughlin, Elizabeth Young, Ivan Young, and Peter Young during the hearing of the Inquest. On the final day of the hearing, Jade's family gave profound and deeply touching family statements.
- 1.20 Mrs Young described the close and loving relationship she had with her daughter, Jade, describing her as lovely, loving, clever, compassionate, thoughtful, slightly goofy, funny and gentle. Jade's parents are shattered by the loss of their daughter.
- 1.21 Peter Young described his much-loved sister as perpetually selfless and a person who, in both her work and life, exemplified goodness. Jade loved her friends and family dearly.

- 1.22 Jade's death has had a devastating impact on those who loved her. I offer my heartfelt condolences to Noel McLaughlin, Elizabeth and Ivan Young, Peter Young, Jade's two young daughters, and her extended family and friends.

Yixuan Cheng

- 1.23 Yixuan Cheng (also known as Josie) was born on 13 March 1997 in Bozhou, China and was 27 years old at the time of her death. Yixuan was the fourth victim and the third victim to sustain fatal injuries. Yixuan was the only child of Jun Xing and Pengfei Cheng and was engaged to be married to her fiancé, Jianguo Wang.
- 1.24 Yixuan had most recently returned to Australia in 2023 to continue her university studies. Yixuan was completing a Master of Economics at the University of Sydney. On 13 April she was shopping at WBJ, having recently completed a university exam.
- 1.25 Ms Xing and Mr Cheng gave a moving family statement describing their love for Yixuan, the wonderful person she was and how she embraced everything around her. As so poignantly described by her parents, Yixuan was on the brink of beginning the most brilliant chapter of her life. Yixuan was the treasure of their lives, and their pain and grief is immeasurable.
- 1.26 I extend my heartfelt sympathy to Yixuan's parents, Jun Xing and Pengfei Cheng, her fiancé Jianguo Wang and Yixuan's family and friends.

Ashlee Good

- 1.27 Ashlee Good was born on 8 July 1985 (age 38 years). She was the ninth victim and the fourth victim to sustain fatal injuries.
- 1.28 Ashlee, who was also known to friends and family as Ash, lived with her partner, Daniel, and their daughter, who at the time of Ashlee's death was only nine months old. Ashlee initially trained as an osteopath before moving into a role in medical sales and the tech industry.
- 1.29 Ashlee died protecting her daughter, who was also attacked by Mr Cauchi. She was a daughter to Denise O'Mahoney and Kerry Good, and a much-loved sibling to Bella, Lainie, Tyson and Sam.
- 1.30 The Court was fortunate to receive family statements from Ms O'Mahoney, Mr Good, Mr Flanagan and three of Ashlee's siblings. These moving statements articulated Ashlee's drive and determination, her joyous disposition, and love of life. Ashlee was a loving mother who adored her precious daughter. Ashlee's actions to protect her daughter highlight her extraordinary courage and bravery.
- 1.31 I offer my sincere and heartfelt condolences to Daniel, Denise O'Mahoney, Kerry Good, Ashlee's siblings, Bella, Lainie, Tyson, and Sam and her extended family and friends.

Faraz Tahir

- 1.32 Faraz Tahir was born on 24 April 1993 in Rabwah, Pakistan. Faraz was 30 years old at the time of his death and was the eleventh victim (and the fifth victim to sustain fatal injuries).
- 1.33 Faraz moved to Australia in December 2022 and is described by his family as a humble, brave and compassionate person. He had left Pakistan in search of safety and freedom, having fled the fear and persecution his family had experienced due to their religious beliefs.
- 1.34 Faraz had five siblings, brothers Muzafar, Mudasir and Sheraz, and sisters Farzana and Durdana. Muzafar and Sheraz attended many days of the Inquest in person, with Faraz's family, who were based overseas, viewing the proceedings via AVL. The Court also acknowledges Muzafar's family, his wife Fahad and their two children, as well as the extended community who supported the family.
- 1.35 The Court was grateful to receive a family statement from Mr Muzafar Ahmad Tahir, Faraz's eldest brother, whose heartfelt words, delivered in English, highlighted Faraz's supportive and kind nature, his love of Australia and how happy he was to have forged his life here.
- 1.36 Faraz's family will remember him as a hero, and a symbol of bravery who will not be forgotten. The Court received a photo compilation of Faraz, which highlighted his love of travel and enjoyment of life.
- 1.37 I offer my heartfelt condolences to Faraz's siblings, Muzafar, Mudasir, Sheraz, Farzana and Durdana, his friends, and the extended community who loved and cared for Faraz.

Pikria Darchia

- 1.38 Pikria Darchia was born on 2 January 1969 and was 55 years old at the time of her death. She was the fifteenth victim (and the sixth victim to sustain fatal injuries).
- 1.39 Pikria was the mother of two sons, Giorgi Darchia and Irakli Divali. Pikria moved to Australia around 2012 with Irakli.
- 1.40 Pikria was a selfless and loving mother who cared deeply for her sons, and her loss has shattered them. They describe Pikria as a kind, strong and calm woman who had many talents and a passion for art.
- 1.41 Tamara Shelia, Pikria's best friend, also told the Court about Pikria's talent, beauty, grace and presence and that she missed Pikria beyond what words can express.
- 1.42 I extend my heartfelt sympathy to Pikria's sons, George and Irakli, Ms Shelia, and Pikria's extended family and friends

Jurisdiction to hold the Inquest

- 1.43 A Coroner has a general jurisdiction to hold an inquest concerning the death or suspected death of a person where it appears that an individual's death is a *reportable death*. A *reportable death* includes circumstances where the individual appears to have died a violent or unnatural death.¹ The six deaths arising from the actions of Mr Cauchi on 13 April 2024 fell within this category. As did Mr Cauchi's.
- 1.44 In addition, under s 23(1) of the Act, a "Senior Coroner" (comprising either the State Coroner or a Deputy State Coroner) has exclusive jurisdiction to hold an inquest into matters where it appears the death has occurred as a result of a *police operation*.
- 1.45 A *police operation* means any activity engaged in by a police officer while exercising the functions of a police officer, other than an activity for the purpose of a search and rescue operation.² It was the actions of Insp Scott in the discharge of her firearm that resulted in the death of Mr Cauchi, and, accordingly an inquest into his death is mandatory.
- 1.46 Section 27 of the Act further provides it was mandatory for the Inquest to be held as:
- (a) It appeared that the person died or might have died as a result of homicide; and,
 - (b) Jurisdiction arose under section 23 of the Act.
- 1.47 While the Inquest was mandatory for the purposes of the Act, families of those who died also specifically requested that an inquest be held to understand what had happened to their loved ones on 13 April 2024 and what, if anything, could have been done differently.
- 1.48 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, manner, and cause of their death.³
- 1.49 Within that statutory role, the Coroner has a broad remit and discretion to consider a wide range of matters falling within his or her jurisdiction, in particular, in relation to the manner (or circumstances) of a death. This is further considered regarding the scope of the Inquest, outlined below.
- 1.50 A key adjunct of the Coroner's statutory mandate under section 82 is the power to make recommendations.⁴ As stipulated by this section, I may make recommendations that are necessary or desirable in relation to any matter connected with a death. The scope of my recommendations function is broad, and without limitation, extends to matters relating to public health and safety.

¹ *Coroners Act 2009* (NSW) ss 21(1)(a), 6(1)(a).

² *Coroners Act 2009* (NSW) s 23(2).

³ *Coroners Act 2009* (NSW) s 81(1).

⁴ *Coroners Act 2009* (NSW) s 82.

- 1.51 While this Inquest cannot change what has occurred, it is hoped that the recommendations arising from this matter, as outlined in these findings, will provide opportunities for reform, certain of which could, in future, save lives.

A trauma-informed approach

- 1.52 At the first directions hearing on 12 November 2024, I acknowledged that the intention of the Court was to conduct the coronial proceedings in relation to the deaths that occurred at WBJ on 13 April 2024 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.⁵
- 1.53 The coronial jurisdiction practices therapeutic jurisprudence, focusing on assisting with the process of grief and healing rather than re-traumatising those directly impacted.⁶
- 1.54 Whilst an inquest into the events of 13 April 2024 was mandatory, a trauma-informed approach to the conduct of these proceedings was a central consideration of the Court. During the coronial investigation process and throughout the Inquest, the Court endeavoured to make the process as comfortable for families as possible with a focus on compassion and listening to their needs.
- 1.55 Noting the significance of the events of 13 April 2024 and the distress caused to so many, the Court was conscious of the need to undertake a thorough investigation of the circumstances as expeditiously as possible and to reinforce the trauma-informed approach through additional services and supports.

Coronial Information and Support Program

- 1.56 The Coronal Information and Support Program (**CISP**) is a service based at the Coroners Court that provides information and support to persons involved in the coronial jurisdiction and assists with facilitating communication.
- 1.57 For this Inquest, there was a dedicated team of CISP officers, who were allocated to each of the victims' families. These officers were able to consistently support the families throughout the entirety of the coronial process.
- 1.58 CISP officers were onsite during the hearing of the Inquest to provide support to families, which included answering questions, ensuring adequate seating in the court gallery, arranging private and comfortable spaces within the court complex to view proceedings, providing food and drink, and giving updates and assistance as needed.
- 1.59 The Court acknowledges the invaluable assistance of the CISP Bondi Junction Inquest team.

⁵ Transcript, Directions Hearing: T2.19-20 (12 November 2024).

⁶ *Commissioner of NSW Police v Deputy State Coroner for NSW* [2021] NSWSC 398 at [3].

NSWPF Family Liaison Officers

- 1.60 NSWPF Family Liaison Officers (**FLOs**) were deployed in the initial aftermath of the events at WBJ. FLOs are police officers who act as a point of contact and offer support to families navigating tragic incidents such as what occurred that day.
- 1.61 FLOs were allocated to each of the victim's families and have provided extraordinary and practical support to assist them with navigating the sudden and unexpected loss of their loved ones.
- 1.62 The Court acknowledges the support provided by the FLOs and FLO coordinator, Senior Sergeant Toni Procter, to the families of the victims, and the attendance of the FLOs at the Inquest.

Traumatic content

- 1.63 The Court was conscious of the impact of traumatic content on families and the extended public in the conduct of the Inquest.
- 1.64 The views of the families were considered regarding traumatic content, and only that which was necessary was shown in the proceedings. During the proceedings, when it was necessary to traverse any sensitive evidence, wherever possible, families were warned to provide the option for them to leave the courtroom or turn off their AVL link. Sensitive evidence, including details of injuries suffered by those who died, was not detailed or shown in Court and was the subject of protective orders.
- 1.65 Control was maintained over what images from the coronial brief of evidence were released to the media. In circumstances where material was proposed to be released, this process was in consultation with the families. In assessing applications for media access to material, the Court was also conscious of the extended harm that could eventuate from wider public distribution of traumatic content.

A flexible hearing approach

- 1.66 To assist families in navigating the coronial process, in particular the hearing itself, the Court adopted a flexible approach to how families could participate in the Inquest.
- 1.67 This included providing families with the option to access an audio-visual link to watch the proceedings from a more comfortable viewing space, such as from home or with other supports in place and providing allocated family breakout rooms at the court complex (with viewing also enabled to the court if required).
- 1.68 Prior to the commencement of the hearing, CISP officers offered families and civilian witnesses the opportunity to view inside the courtroom to help them prepare for the Inquest.

- 1.69 The hearing itself was conducted across two courtrooms, with the main courtroom in which I presided only accessible by direct family and friends of the deceased and legal parties. Interested members of the public typically sat in the gallery of the second courtroom.
- 1.70 A media space was created on a separate level from the courtrooms. Families were afforded additional privacy in the foyer near the courtroom through the use of screening. At the entrance to the Court, a barrier was erected to assist with the management of media.
- 1.71 On the final day of the Inquest proceedings, families were given an opportunity to provide family statements if they wished to do so. Accompanying some of these statements, as referred to above, were images of those who died and some photographs were displayed throughout the hearing. The families gave profoundly moving family statements, graciously sharing with the Court more about the loved ones they have lost.

The hearing process

- 1.72 A public hearing into the deaths that occurred at WBJ on 13 April 2024 commenced as expeditiously as possible, with an opening address delivered by Counsel Assisting on 28 April 2025 at the Coroners Court of New South Wales at Lidcombe, Sydney. This was not long after the first anniversary of the tragic events of 13 April 2024.
- 1.73 It is acknowledged that, given the significance of the incident and the scope of the issues to be canvassed, which I will refer to further below, it was a significant undertaking for the hearing to commence and ultimately conclude within the allocated timeframe. However, it was also considered important to do so, noting the wishes of family members, the significant public interest in these proceedings, and so as to ensure that findings, and in particular recommendations, were delivered as expeditiously as possible.
- 1.74 During the 21 hearing days, commencing on 28 April 2025 and concluding on 29 May 2025, the Court heard evidence from a total of 50 witnesses, including a number of witnesses who gave evidence in conclave. Those witnesses assisted the Court on a variety of topics, which are outlined further below.
- 1.75 In addition to the oral evidence given by witnesses at Inquest, the Court was greatly assisted by an extensive brief of evidence prepared by the officer in charge, Detective Chief Inspector Andrew Marks (**DCI Marks**) and his team, who attended WBJ on the afternoon of 13 April 2024 and worked tirelessly up until, and throughout, the hearing to gather relevant evidence in relation to the events of that day. The brief of evidence was voluminous, consisting of a total of 54 volumes and exceeding more than 35,000 pages.
- 1.76 The Court acknowledges the extensive impact of the events of 13 April 2024 on those who were present at WBJ, including civilian shoppers, workers and those who responded to assist. The Court was conscious of preventing witnesses from being unnecessarily re-traumatised by the process of giving evidence regarding the events of that day,

particularly given the volume of both civilian witness statements obtained by NSWPF investigators and CCTV footage of the events.

Witnesses called at Inquest

- 1.77 Consistent with the trauma-informed approach outlined above, only two civilian witnesses present on 13 April 2024 were called at the Inquest, both of whom were willing to provide oral evidence.
- 1.78 In addition to these civilian witnesses, oral evidence was also called from certain witnesses from various agencies and organisations:
- (a) Officers of the NSWPF and paramedics from NSW Ambulance (**NSWA**) who attended on 13 April 2024;
 - (b) Employees of Scentre Group (**Scentre**), the operator of WBJ, employees of Glad Group (**Glad**), the security contractor retained by Scentre to provide security services at WBJ;
 - (c) Officers of the Queensland Police Service (**QPS**), who interacted with Mr Cauchi in Queensland during the period when he was unmedicated and not receiving regular treatment for his mental health issues;
 - (d) Health practitioners who saw and treated Mr Cauchi in Queensland, including general practitioners, psychiatrists, and nurses; and
 - (e) Executives from many of the involved organisations, including NSWPF, NSWA, the QPS, Scentre and Glad.
- 1.79 In addition to these witnesses, the Court had the benefit of receiving written reports from 11 expert witnesses and heard evidence from many of them during the Inquest. This included international experts from the United Kingdom and Europe. Those experts came from a diverse range of disciplines: psychiatry, general practice, emergency medicine, toxicology, and security. The Court acknowledges the benefit of their expertise in formulating the findings and recommendations arising from the Inquest. Summaries of the expertise of the experts is set out in **Appendix 9**.

Non-publication orders

- 1.80 During the Inquest, there were a number of applications for non-publication and nondisclosure orders. The Court has power to grant non-publication and/or non-disclosure orders pursuant to sections 65(4) and 74(1)(b) of the Act and the Court's implied powers.

- 1.81 The Court considered each of those applications, and certain non-publication orders were made in respect of witnesses, including on an interim basis only.⁷
- 1.82 In summary, non-publication and non-disclosure orders were made in respect of:
- (a) The names of certain individuals, including injured victims present at WBJ on 13 April 2024; certain family members of the deceased, as well as certain involved security guards and first responders from NSWPF and NSWA;
 - (b) Graphic evidence of injuries suffered by the deceased, as well as other sensitive evidence in the coronial brief (such as CCTV footage of the events of 13 April 2024, and body-worn video of NSWPF officers); and
 - (c) Documents concerning sensitive information, including information relating to NSWPF and NSWA operations, as well as material that could potentially compromise the security of WBJ (including services provided by its security subcontractors).
- 1.83 A copy of the Orders can be obtained on application to the Coroners Court Registry.
- 1.84 While no formal pseudonym orders were made in the Inquest, it is noted that for the purpose of these findings, certain witnesses have been referred to by way of pseudonym. Where this is the case, this is stated in these findings by reference to the relevant non-publication order.

Scope of the Inquest

- 1.85 As Counsel Assisting recognised in their submissions, it is important in considering the task of analysing the events of 13 April 2024, and identifying opportunities for improvement, to be conscious of the dangers of hindsight bias and the need to avoid imposing unrealistic standards on the individuals involved who were dealing with such an extreme and then unprecedented event.
- 1.86 Noting this, the focus of the Court and those assisting me was to approach the evidence with a view to systemic learning to the extent possible rather than any individual criticism.
- 1.87 The issues explored during the Inquest were informed and guided by the Issues List, which is replicated at **Appendix 5**. The Issues List was comprehensive, outlining 17 separate issues with multiple subtopics.
- 1.88 An Issues List is not considered a pleading, and the flexible and responsive nature of the inquisitorial jurisdiction of the Court, as expected, led to certain issues on the list

⁷ State Coroner's Ruling – Non Publication Orders – 4 May 2025.

assuming prominence in the hearing, while others were effectively resolved in the course of the investigation.

1.89 As is apparent from the Issues List, there were several central themes that arose from the Court's consideration of the issues.

1.90 Those themes were as follows:

- (a) The events on 13 April 2024, including the preparedness for an active armed offender (also known as an **AAO**) and the response by each of Scentre (and its security subcontractors, including Glad), NSWPF and NSW. In particular, the Inquest addressed:
 - i. The initial response by the security staff at WBJ, including when staff became aware of Mr Cauchi, what actions were taken in response, and the nature and timing of alerts provided to those within the centre; and
 - ii. The response of the NSWPF, including the actions of Insp Scott in fatally shooting Mr Cauchi; how NSWPF interacted with NSW and Scentre and the implementation of relevant command structures, as well as the potential identification of an additional offender (and the consequences this had on the response); and the timing and nature of the response by NSW to the mass casualty incident, including the first aid, treatment, and triage decisions of NSW paramedics, and the circumstances in which WBJ was declared a "hot zone" (requiring paramedics to exit the centre);
- (b) Mr Cauchi's mental health treatment in Queensland, including his treatment for schizophrenia; the decision to reduce, and ultimately cease, his use of psychotropic medication; the consequences of that reduction; whether there were any early warning signs of relapse in late 2019 and early 2020; and if there were any opportunities for intervention that may have prevented what occurred on 13 April 2024;
- (c) The availability of mental health services and other supports (such as accommodation), in NSW and Queensland, for persons such as Mr Cauchi;
- (d) Mr Cauchi's interactions with QPS and NSWPF, including consideration of whether there were any missed opportunities for intervention and how systems can be improved to assist frontline police who are increasingly being asked to deal with members of the public who appear to have mental health issues, and/or are not receiving adequate psychiatric care; and
- (e) The nature of the media response in the aftermath of the events at WBJ.

Acknowledgment

- 1.91 As outlined above, the events of 13 April 2024 have had a profound impact on those who were present that day and the wider community. What ought to have been an unremarkable Saturday afternoon in the Eastern Suburbs of Sydney has changed many lives and devastated those families that lost loved ones.
- 1.92 Whilst it is necessary for the Court to closely examine the response to the events of 13 April 2024, this does not detract from the many acts of considerable bravery displayed by members of the public, staff working at WBJ and emergency services personnel that day. Within the pages of the coronial brief are many such examples of remarkable acts of individuals faced with an unprecedented and unexpected event.
- 1.93 The Court acknowledges the many individuals who responded in a most selfless and heroic manner that day, in particular those who went to the aid of the injured.
- 1.94 On the second day of the Inquest, Insp Scott humbly praised her colleagues in oral evidence and referred to the actions of those around her on 13 April 2024:

I wanted to mention my colleagues and my team on the day. I said earlier we ask a lot of young police, and I think we as a society think that police don't feel fear, don't feel the burden and pressures of what everyday humans do, and I can assure you that they do. I can assure you on that day that they were fearful running in, and whilst I was the person that faced [Mr Cauchi], those young officers ran in with the exact same intentions. Sorry, I may be just emotional talking about them.

... I just want to acknowledge their courage and bravery and some of them haven't been able to return, and they have my wholehearted support, love and care, and... I hope that the public does understand that they were absolutely extraordinary. They saved lives on that day. We did unfortunately lose the lives of six beautiful people but they saved lives and they put themselves at risk. And contrary to how well people think we are trained, we still feel fear, but they still went in there, so I want to acknowledge them in that space, and additionally, in that capacity, I send that out to the ambos that attended, and the often forgotten first responders at the hospitals, and those incredible civilians.

You know, you had young 20 year old shopkeepers dealing with a crisis, you know, adults turning to them going "What do we do?", you know, and [they] all dealt with it. And that day, as tragic as it is, it gave me faith in humanity, restored some faith in humanity and the goodness of people. So I just wanted to mention my colleagues and make sure everyone notes down how extraordinary they are. Thank you.⁸

- 1.95 The Court reiterates the sentiments so humbly expressed by Insp Scott and acknowledges the extreme fear that those individuals, including bystanders, staff and first responders, would have felt confronting what was then an unprecedented situation.

⁸ Transcript, D2 (Scott): T98.35-T99.12 (29 April 2025).

- 1.96 Finally, I must acknowledge, and do so with a deep sense of sadness, the tragic incident at Bondi Beach on 14 December 2025. In light of those terrible events, I took the decision to delay the delivery of these findings. I understand and am sorry for the additional distress this caused to the families of those who lost their loved ones at WBJ. I had hoped that our community would not need to grapple again with such a violent and destructive event; at least not so soon. I express my heartfelt condolences to all who were impacted by these tragic events, especially those who lost their loved ones.

Part 2

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

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

- 2.1. To address the evidence arising in relation to consideration of Issues 3-6, this Part will be divided into the following sections:

Section A	Introduction
Section B	Mr Cauchi's early life
Section C	Initial diagnosis and care in the public system (2001 to 2012)
Section D	Treatment at Mi-Mind Centre (2012 to 2020)
Section E	Treatment from GP Dr Grundy
Section F	Care after Mi-Mind Centre (March 2020 onwards)
Section G	Mr Cauchi's mental state on 13 April 2024
Section H	Relevant policies, guidelines and procedures
Section I	Mental health context in NSW and Queensland

A. Introduction: Mr Cauchi's mental health history (and the mental health context in NSW and Queensland)

- 2.2. Part 2 will address Mr Cauchi's background and mental health history prior to 13 April 2024 (with reference to Issues 3-6 per the Issues List). This includes Mr Cauchi's early life and the emergence of psychotic symptoms, his two admissions to hospital in 2001 and 2002, his mental health care in the public system until 2012, his care from psychiatrist Dr Andrea Boros-Lavack at Mi-Mind Centre from 2012 to early 2020, his care from General Practitioner (**GP**) Dr Richard Grundy, and his limited mental health care after his discharge from the Mi-Mind Centre in early 2020.
- 2.1 This Part will address care and treatment in Queensland. There is no evidence suggesting Mr Cauchi sought or received any mental health care whilst in NSW.
- 2.2 This Part will also consider the broader mental health context in NSW and Queensland, to the extent it arises from a consideration of Mr Cauchi's circumstances.
- 2.3 I am informed by the medical records in relation to Mr Cauchi, statements from people who knew him, and statements and oral evidence from health professionals involved in his care.
- 2.4 In addition, expert evidence was provided by five psychiatrists and two GPs with respect to the mental health care and treatment Mr Cauchi received. Each expert provided an individual report and gave evidence in conclave during the hearing (with the psychiatrist expert conclave occurring on 22 May 2025 and the GP expert conclave occurring on 23 May 2025).
- 2.5 The following psychiatrists provided expert opinion:
- (a) Professor Olav Nielssen: based in NSW, and founder of Habilis.
 - (b) Professor Anthony Harris AM: based in NSW, and involved in the Haven Foundation.
 - (c) Professor Edward (Ed) Heffernan: based in Queensland, and the Director of the Queensland Forensic Mental Health Service.
 - (d) Professor Merete Nordentoft: based in Denmark.
 - (e) Professor Matthew Large: based in NSW.
- 2.6 All of the expert psychiatrists were engaged by the legal team assisting me, other than Professor Large, who was engaged on behalf of Dr Boros-Lavack.
- 2.7 The following GPs also gave expert opinion (and both were engaged by the legal team assisting me):

(a) Dr Hester Wilson: based in NSW.

(b) Dr Edwin Kruys: based in Queensland.

2.8 Counsel Assisting propose that I make a number of recommendations arising from Part 2 of these findings, noting that:

On the basis of the expert evidence the Court heard, we have proposed recommendations aimed at practical changes in the system of healthcare that would dramatically improve the lives of individuals living with treatment resistant schizophrenia and their families and the communities. If implemented, those changes would mean that people like [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.

2.9 The expert psychiatrists and expert GPs have provided their opinions with respect to the formulation of Counsel Assisting's proposed recommendations. The NSW Chief Psychiatrist, Dr Murray Wright PSM, has also contributed to that process.

2.10 I appreciate the insights that the experts and Dr Wright have contributed over the course of the Inquest.

2.11 Counsel for the Good, Singleton and Young families expressed the following sentiment:

From our perspective, one of the most important functions of this inquiry is to look into reforms that are necessary in the funding and in the conduct of the mental health sector in this country. One of the reasons that my clients lost their loved ones, and one of the reasons why many other people were injured, were because of failings within that system. The fact that this young man, a person with a lengthy history of mental health problems, with treatment-resistant schizophrenia, was effectively left unmonitored by any consistent medical specialist for years is unacceptable.

... We're particularly grateful to the experts that have participated in the formulation and reformulation of recommendations that have been put to your Honour in relation to the improvement of the mental health system in Australia.

Overarching considerations

2.12 In considering Mr Cauchi's mental health history, my findings will be based primarily on the facts (sourced from contemporaneous records where possible) and the evidence given by the independent experts. I was very impressed with the evidence of the esteemed experts during the Inquest, and their opinions have assisted me in making my findings.

2.13 Whilst I will of course take into account the submissions made by Counsel Assisting and the parties, I keep in mind that those submissions are necessarily speculative and based on an interpretation of the evidence itself. Given that, my focus will be on the facts and the body of expert opinion.

2.14 The importance of the coronial jurisdiction lies in the ability to consider systemic issues, identify lessons to be learnt, and play a part in preventing future deaths. An inquest is not a forum to criticise the actions of individuals, *unless* analysis of their actions is necessary for lessons to be learnt.

2.15 In considering Mr Cauchi's mental health history, I want to emphasise the importance of not stigmatising, inadvertently or otherwise, those in our community with a lived experience of schizophrenia or any other mental health condition. Counsel Assisting highlighted this during their oral submissions.⁹

2.16 In the words of Professor Nielssen:

*Most people with schizophrenia will never commit an act of serious violence, but a disproportionate number of homicides are committed by people with psychotic illness, usually because of the effect of acute symptoms of mental illness. Most victims are family members and people known to the patient. The homicide of strangers by people with schizophrenia is a rare event ...*¹⁰

2.17 NSW Health highlights that an important underlying principle of mental health services in NSW is that of providing the "*least restrictive care*". To the extent possible, voluntary (rather than involuntary) care should be promoted to encourage recovery-oriented care that aims to empower individuals and prioritises self-determination and autonomy.¹¹

Summary of Mr Cauchi's care and treatment

2.18 My findings are set out in further detail below. There are, however, some salient aspects that I wish to address at the outset.

2.19 There is not one singular reason that Mr Cauchi came to be so unwell on 13 April 2024. Instead, there was a confluence of complex factors.

2.20 While this Part will cover in detail the care that Mr Cauchi received from private psychiatrist, Dr Boros-Lavack from 2012 to early 2020, it cannot be said that Dr Boros-Lavack's care and treatment or decision-making alone resulted in Mr Cauchi being lost to treatment, or that it was the major reason for the events on 13 April 2024. It was part of a matrix and was only one of the factors that led to this tragic outcome.

2.21 The experts opined that Dr Boros-Lavack's care of Mr Cauchi was exemplary for the majority of the time that she saw him. In my view, the care was exemplary prior to October 2019.

⁹ Transcript, Closing Submissions D1: T1889.21-29 (25 November 2025).

¹⁰ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [32].

¹¹ Exhibit 1, Vol 54, Tab 1700, Statement of Dr Murray Wright PSM at [28]-[29], [32].

- 2.22 The body of the expert opinion was not critical of the decision to cease Mr Cauchi's medication, although I note Professor Nielssen opined that in hindsight the decision to cease clozapine was a mistake.
- 2.23 Clozapine in particular is recognised to have serious potential adverse side-effects, and that has to be borne in mind when considering whether it is in the best interests of a patient such as Mr Cauchi to be able to reduce their dose of clozapine.
- 2.24 At the time that Dr Boros-Lavack made a clinical decision to cease Mr Cauchi's anti-psychotic medication, I accept she was aware that there was a 14% chance he would *not* experience a relapse of his condition. This meant she understood there was an 86% chance that he would have a relapse of his condition.
- 2.25 Despite that knowledge, it appears Dr Boros-Lavack was overly optimistic and hoped that Mr Cauchi would be in the 14% that would not relapse. The problem is that this caused Dr Boros-Lavack to develop a confirmation bias and tunnel vision.
- 2.26 As a result, Dr Boros-Lavack did not put enough emphasis on Mr Cauchi's early warning signs, which the experts opine were present when Mr Cauchi was under her care. This is particularly so in terms of the concerns reported by Mr Cauchi's mother, Michele Cauchi to Mi-Mind Centre, including on 20 November 2019 when Mrs Cauchi reported reading Mr Cauchi's notes with content regarding "*under Satanic control*" and on 14 February 2020 when Mrs Cauchi reported 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. In some instances, Dr Boros-Lavack embellished what she thought was positive and minimised anything that may not accord with what she wanted to have occurred – that is, for Mr Cauchi to have recovered and to be in the 14%. This was a misguided approach.
- 2.27 Mr Cauchi's discharge from Dr Boros-Lavack's care in early 2020 was not done well and represents a serious missed opportunity. It was a missed opportunity because if done differently, it may have led Dr Grundy to take more action, including taking more seriously the option to re-call Mr Cauchi.
- 2.28 Dr Boros-Lavack's discharge letter to Dr Grundy dated 19 March 2020 should have included a lot more information. However, I am of the view that Dr Boros-Lavack did not put more information in that letter because she wanted to believe that Mr Cauchi had recovered and was minimising information that pointed against that. I believe that this was a consequence of her confirmation bias.
- 2.29 Dr Grundy should have re-called Mr Cauchi in response to Dr Boros-Lavack's discharge letter.
- 2.30 It is worth noting that between Mr Cauchi's discharge from Mi-Mind Centre in March 2020 and his death on 13 April 2024, a four-year period, Mr Cauchi did see other health professionals (in Queensland).

- 2.31 It was submitted on behalf of Dr Boros-Lavack that Mr Cauchi saw other medical practitioners on 16 occasions between March 2020 and the end of 2023. Further, it was submitted on behalf of Dr Boros-Lavack that:

[Dr Boros-Lavack's] role in trialling an antipsychotic-free medication regime and her largely "exemplary care" over eight years cannot be fairly suggested as a material cause for Mr Cauchi's actions more than four years after his discharge. His subsequent deterioration in mental health is not readily explained, though his resumption of illicit drug use, homelessness, other unhealthy lifestyle choices and a decision to live without previous supports were likely significant factors. The complex reasons for these choices remain unclear.

- 2.32 When Mr Cauchi's treating doctors requested material from the Mi-Mind Centre, they did not receive information regarding the early warning signs that were evident, and they accordingly did not have the benefit of that information. Each of those occasions was a missed opportunity for Mr Cauchi to re-engage with mental health care.
- 2.33 Ultimately, it was submitted on behalf of the Good, Young and Singleton families that I should make a referral to the Health Ombudsman of Queensland in relation to Dr Boros-Lavack. As addressed later in these findings, I have determined to make a referral to the Health Ombudsman of Queensland.
- 2.34 During the Inquest process, there was some speculation as to the motivation for certain aspects of Dr Boros-Lavack's evidence, including her unfortunate evidence on the first day of her oral evidence as to Mr Cauchi's mental state on 13 April 2024, which she withdrew the next day. Dr Boros-Lavack's evidence in that regard is addressed in Part 2, Section G; however, the possible reasons for her evidence can only be a matter of speculation.

B. Mr Cauchi's early life

- 2.35 Mr Cauchi was born on 13 June 1983 and raised in Toowoomba, Queensland by his mother, Mrs Cauchi and father, Andrew Cauchi (Mr Cauchi Snr). Mr Cauchi's older sister also lived in the Cauchi family home.¹²
- 2.36 Mr Cauchi's parents contacted police on the night of 13 April 2024 after seeing footage on television and were interviewed by police on 14 April 2024.¹³ Mr Cauchi's parents and sister also provided written statements to the Court.
- 2.37 Counsel Assisting submitted that Mrs Cauchi and Mr Cauchi Snr "*have cooperated fully with the police investigation and Inquest process*", provided helpful background information regarding Mr Cauchi's mental health and their efforts to get him the care he needed, "*love their son and they cared for him to the best of their ability*", and "*were devastated that he became unwell and that he is responsible for harming others*".¹⁴
- 2.38 It is clear from the evidence that, as submitted by Counsel Assisting, Mr Cauchi's parents cooperated fully with the police investigation and Inquest process and were devastated by the harm their son caused. I am grateful to Mrs Cauchi and Mr Cauchi Snr for their participation and assistance. I know that Mr Cauchi's parents did their best to care for him. They could not have foreseen this tragedy.
- 2.39 Mrs Cauchi described her son as "*a normal child, maybe a little hyperactive, but he wasn't a problem*" and that he was "*very academic*". However, at around age 14 years and by the time he reached Grade 10, Mrs Cauchi describes that Mr Cauchi was "*starting to change*" and was a "*typical teenager getting aggressive*" and in hindsight she considers he may have been starting to become unwell.¹⁵ Mr Cauchi's sister similarly describes that she had gotten on well with her brother but noticed that his behaviour and personality started to dramatically change at around the age of 14, and he told her he had smoked marijuana on approximately three occasions around this time. Mr Cauchi's sister said Mr Cauchi was never physically violent towards her, however she said that he threatened her on at least three occasions.¹⁶
- 2.40 On 11 March 1999, Mr Cauchi (aged 15 years) was first recorded to have attended mental health services, via a school-based Youth Mental Health Nurse Program, following a suspension for smoking marijuana.¹⁷
- 2.41 By Year 12, Mr Cauchi was becoming more obviously mentally unwell and was socially isolated.¹⁸

¹² Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [2], [4].

¹³ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [60].

¹⁴ Written submissions of Counsel Assisting at [76].

¹⁵ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [4]-[6].

¹⁶ Exhibit 1, Vol 15, Tab 774, Statement of Mr Cauchi's sister (unsigned) at [6]-[11].

¹⁷ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at p. 555.

¹⁸ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [7].

- 2.42 Mr Cauchi's aunt recalls an occasion where Mr Cauchi and his cousin had a physical scuffle, and a few punches were thrown after drinking alcohol.
- 2.43 In 2000, Mr Cauchi Snr reported concerns regarding his son on at least three occasions (seemingly to his own GP and to public healthcare service providers). His concerns included Mr Cauchi's aggression, verbal abuse, threatening to kill his father and people in a park, withdrawal and social isolation, and poor memory.¹⁹
- 2.44 Mr Cauchi Snr describes that Mr Cauchi's behaviour started to become "very erratic" and recalls an occasion when Mr Cauchi hit a table with a wrench (when Mr Cauchi Snr had grabbed a hammer) and that Mr Cauchi would repeatedly damage his bedroom door.²⁰
- 2.45 All of the expert psychiatrists agreed that by the time Mr Cauchi was in his late teenage years, he had psychosis and/or schizophrenia.²¹ Professor Nielssen commented that Mr Cauchi's duration of untreated psychosis was probably "a little shorter than a year".²²
- 2.46 The evidence also suggests Mr Cauchi may have a family history of a mental health condition involving delusional thinking, possibly schizophrenia (undiagnosed).
- 2.47 Counsel Assisting submitted:

It is abundantly clear that Mr Cauchi was deeply loved by his family, and particularly by his parents, who did their best to care for him.

Mr Cauchi's mental health issues resulted in a change in his behaviour from around the age of 14 and coincided with a time when he was smoking marijuana. While there is a known link between marijuana use and psychosis, it is also the case that persons suffering from a mental illness may self-medicate with cannabis, which ultimately worsens their psychiatric condition. That appears to be the case for Joel Cauchi.

By the time Mr Cauchi was taken by police to hospital for the first time in 2001, he was exhibiting obvious psychosis, exhibited by auditory, visual and tactile hallucinations. His behaviour also manifested in anger and physical violence.²³

- 2.48 I accept those submissions.

¹⁹ Exhibit 1, Vol 16, Tab 783, Toowoomba Base Hospital records (Part 1) at p. 19.

²⁰ Exhibit 1, Vol 15, Tab 773, Statement of Andrew Cauchi at [10]-[11].

²¹ Transcript, D16 (Nielssen/Heffernan/Harris/Nordentoft/Large): T1397.7-T1398.36 (22 May 2025).

²² Transcript, D16 (Nielssen): T1398.49-T1399.2 (22 May 2025).

²³ Written submissions of Counsel Assisting at [511]-[513].

C. Initial diagnosis and care in the public system (2001 to 2012)

First hospital admission (January to February 2001)

2.49 Mr Cauchi was first admitted to hospital for mental health care from 26 January to 23 February 2001, aged 17 years. His parents rang the police after Mr Cauchi damaged the back door of the Cauchi family home. Mr Cauchi was taken to Toowoomba Hospital by police.²⁴

2.50 A progress note of the on-call psychiatry registrar at around the time of Mr Cauchi's admission included the following, which gives an overview of the symptoms of his first episode of psychosis:

Prior to this – approximately for two weeks – Joel claimed that he was 'feeling' & 'seeing' the 'demons' entering into his body. He was observed to be scratching the body or making movements to "pull out the demon or Devil" from his body. This behaviour became worse for the past one week. Today he told his father that he was possessed by the Devil and tormented by that and declared as follows

"Either the problem will be gone within this two weeks or I will be gone" (suggestive of suicidal intent)

Whereas Joel admitted to me that he had this 'spiritual problem' since Sept 2000.

He narrated that he saw Frogs trying to swallow him or swallowing him – Inside the Frog he saw other persons also.

This was also accompanied by bad smell. Claimed that he had these experiences at least twenty times.

At least more than three times he felt like somebody grappling him & pulling him down into a trap. Also one occassion [sic] saw a giant Frog (1 ½ metre tall & 3m. long) on the road side.

Expressed ideas of persecution – claimed that two men were after him. Parents said that during Dec 2000 two men punched on his car window after an incident in the play ground. Recently Joel dyed his hair, started wear a base ball hat, and was found to be wearing sunglasses day & night.

Also he claimed to the parents that other people were attempting to put thoughts into his mind – (Joel claimed that two yrs ago he underwent hypnosis)

*No h/o drug or alcohol abuse for the past 18 months...*²⁵

2.51 On 23 February 2001, Mr Cauchi was discharged from hospital. Per the discharge summary, Mr Cauchi was diagnosed with schizophreniform disorder, he had been commenced on olanzapine, and his mental state had gradually improved in hospital.

²⁴ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 632-675.

²⁵ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 634-635.

Mr Cauchi was to have follow-up with the Child and Youth Mental Health Service in the community.²⁶

Care in the community (2001 to 2002)

- 2.52 From the time of the hospital discharge on 23 February 2001 until early 2012, Mr Cauchi received care from youth, and then adult, public mental health teams in Queensland.
- 2.53 From 2001 to 2019, Mr Cauchi's private treating GP in the community was Dr Grundy at St Andrews Medical Centre in Toowoomba.²⁷
- 2.54 From March to November 2001, the evidence suggests Mr Cauchi attended and/or had an interest in attending gun or similar clubs. In November 2001, he sought to obtain a weapons licence "*to buy a gun for use at the gun club*".²⁸
- 2.55 From at least June 2002, medical records refer to Mr Cauchi having symptoms of Obsessive Compulsive Disorder (OCD).²⁹
- 2.56 In July 2002, a plan was recorded to gradually introduce risperidone (to improve concentration) and to reduce and eventually cease olanzapine.³⁰
- 2.57 Professor Nielssen commented that "*it seems that [Mr Cauchi] continued to have symptoms despite treatment with those two medications*" (olanzapine and risperidone), and that negative symptoms probably also contributed to a decision to initiate clozapine.³¹
- 2.58 Counsel Assisting submits, with reference to events in the medical records in August and September 2002, that: "*It is patently clear that Mr Cauchi continued to experience positive symptoms of schizophrenia during this period.*"³² I accept this submission.

Second hospital admission (October 2002) and clozapine commencement

- 2.59 From 1 to 15 October 2002, Mr Cauchi (aged 19 years) was hospitalised for his mental health for the second (and final) time. He was admitted to Toowoomba Base Hospital to manage a medication change, from risperidone to clozapine, upon referral from Dr Nicky Stephens (his psychiatrist in the community).³³

²⁶ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 560-562.

²⁷ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 220.

²⁸ Exhibit 1, Vol 16, Tab 783, Toowoomba Base Hospital records (Part 1) at pp. 291, 298; Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at p. 433.

²⁹ Exhibit 1, Vol 16, Tab 783, Toowoomba Base Hospital records (Part 1) at p. 33; see also Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [63] and Transcript, D16 (Nielssen): T1400.6-24 (22 May 2025).

³⁰ Exhibit 1, Vol 16, Tab 783, Toowoomba Base Hospital records (Part 1) at p. 43; Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 520-521; see also p. 522.

³¹ Transcript, D16 (Nielssen): T1400.45-T1401.1 (22 May 2025).

³² Written submissions of Counsel Assisting at [112].

³³ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 521, 559 – 597, 564-575.

- 2.60 Upon discharge on 15 October 2002, Mr Cauchi's diagnosis was schizophrenia. His treatment plan was to continue clozapine (300mg daily).³⁴

Care in the community (2002 to 2012)

- 2.61 Mrs Cauchi later reported that Mr Cauchi's OCD traits worsened after Mr Cauchi commenced clozapine.³⁵
- 2.62 Upon discharge from hospital in October 2002, Mr Cauchi returned to the care of a public health team. From October 2006 to early 2012, Mr Cauchi was case managed by psychologist, Dr Paul McQueen. Dr McQueen provided Mr Cauchi with Cognitive Behavioural Therapy (CBT) in relation to OCD from 2006 to 2007.³⁶
- 2.63 Dr McQueen considers that from that point in time, until discharge in March 2012, Mr Cauchi remained "*largely stable*" apart from a brief period of mildly increased positive symptoms in the context of the change of his brand of clozapine.³⁷

Change in clozapine brand and addition of Abilify (aripiprazole)

- 2.64 At some time between January and April 2007, Mr Cauchi's clozapine brand was changed from Clozaril to Clopine.³⁸ This was a change made for all patients in Queensland who were prescribed clozapine at that time.³⁹
- 2.65 Mr Cauchi experienced a brief period of mildly increased symptoms in the context of the brand change, however, he alerted his treating team and those resolved with a small adjustment to his medication dose.⁴⁰
- 2.66 Mr Cauchi was performing rituals and had persecutory ideas (including in relation to Gods, and to devils killing him) and medical notes record: "*passivity phenomenon persists ++*", "*? Auditory hallucinations*", "*Tactile hallucinations ++*", and "*Risk of deterioration + ++*". The impression recorded was of relapsing schizophrenia ("*? cause*") and exacerbation of OCD.⁴¹
- 2.67 On 3 July 2007, Mr Cauchi commenced Abilify (aripiprazole), in addition to clozapine (600mg per day), in order to manage his symptoms.⁴²

³⁴ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at p. 559.

³⁵ See Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 73, 76-78.

³⁶ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [2], [9]-[11].

³⁷ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [13].

³⁸ Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 90-91; Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at p. 102.

³⁹ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [13].

⁴⁰ Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at pp. 102-103, 123-125, 497-499; Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [13].

⁴¹ Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at pp. 123-125, 497.

⁴² Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at pp. 124-125, 497.

- 2.68 From 2007 to 2016, GP Dr Frank Golik saw Mr Cauchi on ten occasions in relation to “Bio Balance”,⁴³ which is reported to be a nutrient based therapy.⁴⁴
- 2.69 On 20 December 2011, Mr Cauchi’s clozapine dose was reduced from 600mg to 550mg nocte (that is, at night), whilst under the care of the public Adult Mental Health Service (AMHS). The medical notes record Mr Cauchi was “*vague regarding the motivating factors*” for wanting the reduction. It followed Mrs Cauchi requesting that this reduction occur after Mr Cauchi finished his studies.⁴⁵
- 2.70 Counsel Assisting submitted that:
- ... from October 2002 until 2012, Mr Cauchi continued to experience “some positive symptoms ... with fluctuating severity” and also significant negative symptoms of schizophrenia. Unsurprisingly, he had difficulty socialising with others, and that led to social isolation.*⁴⁶
- 2.71 Mr Cauchi’s fluctuating positive symptoms of schizophrenia included auditory hallucinations (hearing voices), tactile hallucinations, and believing that photographs were sending him messages.⁴⁷
- 2.72 I accept the submissions of Counsel Assisting.

Discharge from the public system (2012)

- 2.73 In Queensland in late 2011, certain patients who had been stable on clozapine began to have their mental health care transferred to private clinics which were, for the first time, able to prescribe clozapine outside of the public mental health service.⁴⁸ According to Dr McQueen, Mr Cauchi was a good candidate for transfer of care, since he had shown good insight into his illness, had consistently adhered to treatment, had no significant risk factors identified, and had considerable family support.⁴⁹
- 2.74 On 6 February 2012, Mr Cauchi was seen by a psychiatrist from the public health team (who had not seen him previously) as well as Dr McQueen, with Mrs Cauchi present.⁵⁰ The record of that consultation notes:⁵¹

(a) “*Because of the side effects, on a reducing course of Clozapine now*”;

(b) “*Plan:*

⁴³ Exhibit 1, Vol 22, Tab 812, Statement of Dr Frank Golik at [3]-[8]; see, for example, Exhibit 1, Vol 15, Tab 782, Toowoomba Base Hospital records at pp. 11-12.

⁴⁴ Exhibit 1, Vol 21, Statement of Dr Joanne Barkla at [6].

⁴⁵ Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at pp. 226, 345-347.

⁴⁶ Written submissions of Counsel Assisting at [142].

⁴⁷ Exhibit 1, Vol 16, Tab 783, Toowoomba Base Hospital records (Part 1) at pp. 65, 75-76, 92, 462-463; Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital records (Part 1) (continued) at pp. 462-463; Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 15; Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 17-19, 36, 49-50.

⁴⁸ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [14].

⁴⁹ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [14]-[15].

⁵⁰ Exhibit 1, Vol 15, Tab 781A, Statement of Dr Manoj Narayanan at [4]-[7].

⁵¹ Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 230-231.

Discussed about the early warning signs especially when reducing dose.

Suggested a slow tapering to target a dose range of 300-400 [mg] and to check levels once reached 400mg.

A reduction of 25-50mg at a time”;

(c) “CM [case manager] discussed the option of transferring to a pvt [private] Psychiatrist for clozapine [follow up] to ensure continuity of care, which patient will consider soon”; and

(d) “Not to stop Aripiprazole while making the changes in Clozapine”.

- 2.75 Dr McQueen states that when he last saw Mr Cauchi in February 2012, Mr Cauchi’s mental health remained stable with no overt psychotic symptoms, and he was adherent to his treatment.⁵²
- 2.76 Dr McQueen also states that the actions of Mr Cauchi on 13 April 2024 “in no way resembled the personality, character or state of mind of Mr Cauchi in the time that I was involved in his care.” Dr McQueen described Mr Cauchi as “a quiet, polite and cooperative ... individual who was engaged in his own mental health treatment and adherent to the recommendations of his treating team”. Dr McQueen could not recall any instance of Mr Cauchi expressing or displaying thoughts or emotions relating to aggression or violence, and this was supported by his review of the notes.⁵³
- 2.77 On 20 February 2012, Dr Grundy referred Mr Cauchi to private psychiatrist, Dr Boros-Lavack at the Mi-Mind Centre in Toowoomba for treatment and management (as requested by Mrs Cauchi).⁵⁴
- 2.78 On 19 April 2012, Dr McQueen contacted Mrs Cauchi regarding the transition of care,⁵⁵ and Mr Cauchi was formally discharged from the care of the public mental health service. Upon discharge, Mr Cauchi’s diagnosis was recorded as “*paranoid schizophrenia*”. The discharge summary from the AMHS to Mi-Mind Centre provided (amongst other things):

Joel has been treated with Olanzapine and Risperidone in the past with poor response to these treatments. He has been stable since being commenced on Clozapine. He has now been treated with Clozapine for around 10 years.

It appears that Joel may continue to experience some positive symptoms, with fluctuating severity. However, Joel denies any positive symptoms. If symptoms are present they do not interfere with his functioning. ...

*Negative symptoms remain a feature of his illness. ...*⁵⁶

⁵² Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [17]. Note: Dr McQueen refers to this being on 14 February 2012, however it could possibly also be referring to the 6 February 2012 instance mentioned above.

⁵³ Exhibit 1, Vol 15, Tab 781, Statement of Dr Paul McQueen at [20], [24].

⁵⁴ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 220.

⁵⁵ Exhibit 1, Vol 15, Tab 782, Toowoomba Base Hospital records at p. 74.

⁵⁶ Exhibit 1, Vol 18, Tab 784, Toowoomba Base Hospital records (Part 2) (continued) at pp. 497-500.

Overview of care in the Queensland public system

Expert evidence

- 2.79 Professor Nordentoft opined that “*Mr Cauchi received a high quality of care in the first years of his severe illness*”.⁵⁷
- 2.80 Professor Heffernan opined that the decision to refer Mr Cauchi to the Mi-Mind Centre in 2012 would have been appropriate at the time, under the assumption that there was to be ongoing care and treatment with clozapine.⁵⁸

Submissions

- 2.81 With respect to Mr Cauchi’s care in the Queensland public health system, Counsel Assisting submitted as follows:

- (a) “*In our submission your Honour would find that from 2002 to 2012 [Mr Cauchi] was managed very effectively in the community by the public mental health team*”;⁵⁹
- (b) “*The expert panel agreed that Mr Cauchi receive[d] mental healthcare of a very high standard in the Queensland public health system, over that period of time, both as an inpatient and through the community mental health team.*

Professor Nordentoft notes that he was seen frequently by a psychiatrist and followed with case management from a multidisciplinary team, who saw him during home visits, had meetings with his mother and had multidisciplinary team conferences about his condition. She also noted that his cognitive functioning was thoroughly assessed with an appropriate battery of gold standard tests”;⁶⁰

- (c) “*... No doubt Mr Cauchi’s stability and progress was greatly assisted by the proactive work of his parents, particularly Michele Cauchi, and by the love and support of both parents. It is also clear that Mr Cauchi himself was a compliant patient during this period*”;⁶¹ and
- (d) “*Mr Cauchi saw the same psychologist (Dr McQueen) over many years and the same psychiatrist (Dr Stephens) and appeared to develop a good rapport, to good effect. He remained compliant and engaged with his treatment and enjoyed the support of his devoted parents*”.⁶²

- 2.82 With respect to Mr Cauchi’s discharge from the public system to the Mi-Mind Centre in 2012, Counsel Assisting submitted:⁶³

⁵⁷ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [81].

⁵⁸ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [4.1].

⁵⁹ Transcript, Closing Submissions D1: T1898.18-20 (25 November 2025).

⁶⁰ Transcript, Closing Submissions D1: T1899.30-38 (25 November 2025).

⁶¹ Written submissions of Counsel Assisting at [155].

⁶² Written submissions of Counsel Assisting at [525].

⁶³ Written submissions of Counsel Assisting at [164], [166].

- (a) *“The decision to transfer Mr Cauchi’s care from the public system to the private one was reasonable in the circumstances, given a) Mr Cauchi’s compliance with medication and treatment; b) his years of relative stability; c) his willingness to report symptoms as they arose; d) a supportive family and e) the plan that he would continue with medication”*; and
- (b) *“At the time of Mr Cauchi’s discharge from the public system, it was clearly not envisaged that he would be weaned off all medication”*.

Findings

- 2.83 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.

D. Treatment at Mi-Mind Centre (2012 to 2020)

Mi-Mind Centre structure

- 2.85 From March 2012 to early 2020, Mr Cauchi was a patient of Dr Boros-Lavack at the Mi-Mind Centre in Toowoomba, whom he generally saw on a monthly basis. Mr Cauchi saw other psychiatrists at the Mi-Mind Centre when Dr Boros-Lavack was unavailable, on a small number of occasions.⁶⁴
- 2.86 At the time that Mr Cauchi received care at the Mi-Mind Centre, it delivered a Mental Health Nurse Care Program (**MHNCP**), which was commissioned by the Darling Downs West Moreton (**DDWM**) Public Health Network (**PHN**).⁶⁵ Mr Cauchi saw a nurse through that program on a regular (approximately monthly) basis. Mr Cauchi's clozapine coordinator/case manager was RN Debbie Moody until August 2015, RN Clare Schwarz until January 2018, and RN Andrea Brooks until 2020. The nurse's role included ongoing mental state examinations and monthly Clopine clinics to monitor the patient.⁶⁶
- 2.87 Mi-Mind Centre also operated a Peer Support Program from 1 July 2019 to 30 June 2020, which Mr Cauchi engaged with in around late 2019.⁶⁷ That program was facilitated by the DDWM PHN.⁶⁸
- 2.88 According to RN Schwarz, weekly multi-disciplinary team (**MDT**) meetings would occur and be attended by the nurses and psychiatrists. Mr Cauchi was discussed during those meetings on occasion.⁶⁹
- 2.89 In terms of the Mi-Mind Centre set-up, Professor Nielssen commented that it "was exemplary in some ways", with the key benefit being that there was one doctor all the time, with appropriate supports and coverage.⁷⁰ Professors Harris and Heffernan considered that an MDT with allied health, and assistance to obtain employment and find a social network, would have been best.⁷¹ Professor Nordentoft gave evidence that the Danish public system is similar to the Mi-Mind Centre structure, although possibly with access to more services, which allows it to be "more assertive" (such as by conducting home visits, involving relatives and encouraging them to report warning signs, and being persistent if the patient is not attending planned visits).⁷² Professor Large indicated a general preference for patients such as Mr Cauchi to be cared for in the public system.⁷³

⁶⁴ Exhibit 1, Vol 19, Tab 792, Statement of Dr Snezana Alempijevic at [4]-[5].

⁶⁵ Exhibit 1, Vol 50, Tab 1619A, Statement of Lucille Chalmers (Chief Executive Officer, Darling Downs and West Moreton Primary Health Network) at [17].

⁶⁶ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [22]-[31].

⁶⁷ Exhibit 1, Vol 20, Tab 793A, Response from Mi-Mind Centre at p. 5.

⁶⁸ Exhibit 1, Vol 19, Tab 792C, Statement of RN Clare Schwarz at [18].

⁶⁹ Transcript, D10 (Schwarz): T783.32-44 (12 May 2025).

⁷⁰ Transcript, D16 (Nielssen): T1412.44-46 (22 May 2025).

⁷¹ Transcript, D16 (Harris/Heffernan): T1413.22-50 (22 May 2025).

⁷² Transcript, D16 (Nordentoft): T1415.36-T1416.15 (22 May 2025).

⁷³ Transcript, D16 (Large): T1414.9-13 (22 May 2025).

Treatment from 2012 to 2015

Diagnosis at Mi-Mind Centre

- 2.90 On 6 March 2012, Dr Boros-Lavack saw Mr Cauchi for the first time, with Mrs Cauchi also present. Dr Boros-Lavack recorded a diagnosis for Mr Cauchi of chronic paranoid and disorganised schizophrenia, which was in control on Clopine, and OCD.⁷⁴
- 2.91 In her oral evidence, Dr Boros-Lavack indicated that she initially diagnosed Mr Cauchi, as a working diagnosis, with chronic (treatment resistant) schizophrenia (paranoid and disorganised); however, after she received a letter/discharge summary from the hospital/public health team, she revised that diagnosis to first episode psychosis, which remitted on clozapine. Dr Boros-Lavack indicated in her oral evidence that the first episode lasted for a long period of time, until 2008.⁷⁵
- 2.92 From March 2012 to June 2019, Professor Nielssen opined (and Professor Heffernan agreed) that Mr Cauchi's symptoms seemed to be chronic cognitive symptoms of schizophrenia, negative symptoms, *"very likely a lower level of ... hallucinations, although they're not documented..."*, and continuing symptoms of OCD.⁷⁶ Professor Nielssen agreed that Mr Cauchi was stable, although symptomatic to some lower level.⁷⁷

Whether Mr Cauchi had "treatment resistant", "chronic" and/or "first episode" schizophrenia and/or psychosis

- 2.93 In their oral evidence, the expert psychiatrists agreed that Mr Cauchi had schizophrenia, and it was chronic.⁷⁸
- 2.94 Professor Nordentoft gave evidence that: *"... I think it would be wrong to characterise him as a patient with first episode psychosis. He's far beyond that. It is a chronic condition. ..."*⁷⁹
- 2.95 Professor Heffernan explained that the lack of response to two adequate trials of antipsychotic medication is consistent with schizophrenia being "treatment resistant" (although noting that term is not defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM)).⁸⁰
- 2.96 Professor Nordentoft ultimately gave oral evidence that whilst Mr Cauchi fulfilled the criteria for "treatment resistant" schizophrenia for many years, he did end up having some response to clozapine, and on reflection Professor Nordentoft considered that Mr

⁷⁴ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 88, 132; Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [3].

⁷⁵ Transcript, D11 (Boros-Lavack): T896.1-50, T898.1-T906.50, T920.1-T921.50 (13 May 2025); Transcript, D12 (Boros-Lavack): T989.1-50, T996.1-T1000.50, T1034.1-T1036.50, T1050.1-1051.50 (14 May 2025).

⁷⁶ Transcript, D16 (Nielssen): T1411.1-8 (22 May 2025).

⁷⁷ Transcript, D16 (Nielssen): T1410.34-46 (22 May 2025).

⁷⁸ Transcript, D16 (Nielssen/Large/Harris/Heffernan/Nordentoft): T1409.17-20, T1410:12-20, T1410.48-T1411.1-32 (22 May 2025).

⁷⁹ Transcript, D16 (Nordentoft): T1423.13-26 (22 May 2025).

⁸⁰ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [2.6], [2.11], [2.44].

Cauchi's schizophrenia should not be referred to as "*treatment resistant*" (and instead should be referred to as "*chronic*").⁸¹

Submissions

- 2.97 The submissions of Counsel Assisting referred to Dr Boros-Lavack's first statement in this Inquest (dated 7 June 2024), in which she stated as follows:

Question 4. Mental Health status of CAUCHI

*Answer 4: Throughout my treatment of him from 6 March 2012 until 17 February 2020 Joel remained generally well. His mental status was euthymic and apsychotic. Joel did not have chronic schizophrenia and he maintained a complete late phase recovery from his single first episode of schizophrenia. A more detailed description of his mental health status is set out in the body of my statement above.*⁸²

- 2.98 Counsel Assisting submitted as follows:

The characterisation of Mr Cauchi's illness as a first episode psychosis by Dr Boros-Lavack was, at best, misconceived, but more likely deliberately disingenuous.

Each of the expert psychiatrists who gave evidence before the Inquest agreed that Mr Cauchi suffered chronic schizophrenia.

...

*It is inescapable that Mr Cauchi did suffer from chronic (treatment-resistant) schizophrenia. If Dr Boros-Lavack was intending to argue that Mr Cauchi had experienced first episode psychosis while in the public hospital system, but that he was no longer suffering that illness by the time she first saw him in 2012, or ceased all medication in 2018, then that is a fundamental lack of understanding as to the illness he suffered. More likely, Dr Boros-Lavack was attempting to recast Mr Cauchi's illness to justify why she was able to [wean] him off all medication and to try and justify her claim, on the first day of giving evidence, that Mr Cauchi was not unwell when he acted so violently on 13 April 2024. ...*⁸³

- 2.99 Counsel Assisting submitted that Dr Boros-Lavack's evidence contained contradictions and was confusing and wildly inconsistent at times with respect to use of terminology, which was an attempt to re-characterise the illness and give the impression that Mr Cauchi had fully recovered from an initial episode of schizophrenia to justify her subsequent decision-making (rather than it being a result of confusion around terminology).⁸⁴ Further, Counsel Assisting submitted that it is incorrect to say that Mr Cauchi's symptoms ever resolved entirely.⁸⁵

⁸¹ Transcript, D16 (Nordentoft): T1410.12-20 (22 May 2025).

⁸² Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at p. 19.

⁸³ Written submissions of Counsel Assisting at [184]-[185], [189].

⁸⁴ Transcript, Closing Submissions D1: T1903.23-50 (25 November 2025).

⁸⁵ Transcript, Closing Submissions D1: T1898.40-47 (25 November 2025).

- 2.100 Counsel Assisting proposed a recommendation to clarify certain terminology, as addressed later in this Part.⁸⁶
- 2.101 The submissions on behalf of the Good, Singleton and Young families agreed with certain submissions of Counsel Assisting and submitted that Dr Boros-Lavack's evidence regarding a revised diagnosis of first-episode schizophrenia was a recent invention to attempt to justify her decision-making.⁸⁷
- 2.102 The submissions on behalf of Dr Boros-Lavack, responding to a submission on behalf of those families that Dr Boros-Lavack first characterised Mr Cauchi's illness as a "*single first episode of schizophrenia*" in her statement dated 7 June 2024, referred to a form in the medical records titled "*Therapy Event/Termination of Treatment*".⁸⁸ That form was completed by Dr Boros-Lavack on 28 June 2018 with respect to the cessation of clozapine. Under "*Ceased due to medical reasons (not listed above)*", Dr Boros-Lavack wrote: "*Recovered from 1st episode psychosis and remained well with no relapse over the past 16 years!*". The form also indicated that there had been no precipitating event "*except discontinuation of Clopine due to successful treatment*".⁸⁹
- 2.103 In summary, it was also submitted on behalf of Dr Boros-Lavack as follows:⁹⁰
- (a) Dr Boros-Lavack's diagnosis was of prolonged "first episode" psychosis, or "first episode" schizophrenia. The experts did not agree with that diagnosis; however, the label did not make any difference to the treatment provided.
 - (b) "*At times [Dr Boros-Lavack] accepted the labelling of his condition as "chronic" but her evidence was at times confusing. The reasons for that confusion are likely to have been influenced by her explanation given at the outset on day 2 of her oral evidence*". Elsewhere, it is submitted: "*[Dr Boros-Lavack] conceded that as well as being first episode, it was a "chronic" form of the illness*".
 - (c) Dr Boros-Lavack "*readily accepted*", "*repeatedly*" that Mr Cauchi was suffering chronic schizophrenia. She preferred to label it as first episode schizophrenia over a very long period, whilst acceding to the suggestion many times that it was chronic and required lifelong monitoring.
 - (d) Counsel Assisting's (and the Families') submission, that Dr Boros-Lavack's characterisation of Mr Cauchi's illness as first episode psychosis was misconceived or deliberately disingenuous, to justify her treatment decisions and her (withdrawn) evidence regarding Mr Cauchi's condition on 13 April 2024, should be withdrawn and "*should be roundly rejected and is not sustainable*".

⁸⁶ Transcript, Closing Submissions D1: T1904.1-9 (25 November 2025).

⁸⁷ Written submissions on behalf of the Good, Singleton and Young families at [4.6], [4.10]-[4.19].

⁸⁸ Written submissions on behalf of Dr Andrea Boros-Lavack at [5.9]-[5.10].

⁸⁹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 170.

⁹⁰ Written submissions on behalf of Dr Andrea Boros-Lavack at [5.1]-[5.10]; Transcript, Closing Submissions D2: T1981.11-18 (28 November 2025).

- (e) Definitions including of “first episode”, “treatment resistant” and “chronic” schizophrenia are not particularly helpful as they are not used consistently. Given confusing and different understanding of terms, the labels are of marginal significance *“when there was no contest between [Dr Boros-Lavack] and the expert psychiatrists that [Joel Cauchi]’s “unusual” type of schizophrenia was a serious condition requiring lifelong monitoring in order to try and ensure that the high risks of any possible relapse of psychotic symptoms were suitably addressed”*.

Findings

- 2.104 In making findings as to Mr Cauchi’s diagnoses, I rely heavily on the expert opinions.
- 2.105 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 of 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.
- 2.106 The common position of the expert psychiatrists appears to be that Mr Cauchi did *not* have first episode psychosis (or first episode schizophrenia).
- 2.107 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.
- 2.108 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, as Dr Boros-Lavack provided as a reason for ceasing clozapine in 2018 (on the “Therapy Event/Termination of Treatment” form): *“Recovered from 1st episode psychosis and remained well with no relapse over the past 16 years!”*. I note, however, that the experts did not agree that it was accurate to say that Mr Cauchi had no relapse for 16 years.
- 2.109 I also note that Dr Boros-Lavack’s earlier letter dated 6 May 2015 to Dr Grundy (requesting a referral for a second opinion from Dr Stephens) stated: *“He was started on Clozapine for his first episode of Schizophrenia at age 17 (2001)...”* (as well as *“I do believe Joel needs an antipsychotic for long term relapse prevention”*). Further, a letter from Dr Boros-Lavack to Dr Grundy dated 1 June 2017 provided: *“I’m pleased to report that Joel’s first episode Schizophrenia occurred 17 years ago has remained in sustained full remission for the past 15yrs on Clopine, which we have been gradually discontinuing over the past 5yrs or so without rebound [or] relapse. ...”*⁹¹.
- 2.110 The experts opined that Mr Cauchi did have chronic schizophrenia.

⁹¹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 192.

- 2.111 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. 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 (as addressed further elsewhere in this Part).
- 2.112 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).
- 2.113 Professor Harris gave evidence as follows regarding terminology:

Chronicity, the diagnosis of a chronic schizophrenia suggests that the symptoms have gone on for at least two years without a remission of those symptoms giving - and the, the treatment resistance part of it, the diagnosis, is really a reflection of the criteria for starting clozapine. So has the person responded to one of two different antipsychotics initially given? If not, they're designated as having treatment resistance, and they're eligible for the initiation of clozapine under present Australian rules.

So Mr Cauchi had an unusual illness in that he didn't remit from his initial illness for the first couple of years, and so although in theory he - well, he can be described as having a first episode schizophrenia, that there was no real cessation of his symptoms. He didn't go into remission from the period of time when he was, first arrived in Toowoomba Base Hospital to around - well really to about 2011, 2012. However, he had chronic schizophrenia over that period of time because of the duration of his symptoms.⁹²

- 2.114 Professor Heffernan explained:

I might make a comment. So, so - and I'll probably be repeating some of what Professor Harris has said, so one of the specifiers is about treatment, the treatment things, that's treatment-resistant, and that's all about clozapine. And then the other specifiers are time specifiers, so they're kind of in the same category. So first episode, and chronic, are time specifiers. The [DSM-V] hasn't helped us in, in the way it defines these things, because it does - it's a little bit open to interpretation. But what the [DSM-V] says is that the first, the first episode, the way I interpret it and the way it's written is that it's the first manifestation of the disorder meeting the defining diagnostic symptoms and time criterion.

So in other words, one interpretation, and I think probably a commonly used interpretation, is that first presentation to hospital Mr Cauchi was identified with the symptoms that met the diagnosis of schizophrenia and he was identified with the time

⁹² Transcript, D16 (Harris): T1471.36-50 (22 May 2025).

*criteria this has been going on for six months. That's his first episode. Whatever happens after that, we move on, and if he continues to have symptoms, there is no criteria defined in the [DSM-V] for chronic - I think there was in the DSM-IV, and I believe it was a two year specifier. And I think if you asked most clinicians and showed them the chronology of Mr Cauchi's illness they would say that was his first episode in 2001, and he's got chronic schizophrenia.*⁹³

- 2.115 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 was asked if he agreed with Professor Heffernan's opinion and gave the following evidence:

*Definitely, yes. It's - well, firstly, I - I'd say schizophrenia - all, all schizophrenia is treatment-resistant, really. If you fully recover in all respects, including functional recovery after having had a - an episode of psychosis, defined by having had a delusional belief, then it's not schizophrenia. Schizophrenia has residual impairment. But, however, the - it's the more severe impairment and the, and the presence of continuing active symptoms that, that lead you to say it's a treatment-resistant form of schizophrenia. But, but, yeah clozapine is the best we have.*⁹⁴

OCD diagnosis

- 2.116 Professor Harris gave evidence that Mr Cauchi was appropriately diagnosed with OCD.⁹⁵

- 2.117 Professor Heffernan opined:

*There seems to be little doubt [Mr Cauchi] developed symptoms of OCD. This condition is not uncommon in people with schizophrenia and there is evidence it can be associated with clozapine treatment. It is possible that [Mr Cauchi]'s experience of OCD was associated with the commencement of clozapine. ...*⁹⁶

- 2.118 Professor Nordentoft opined that Mr Cauchi “*developed Obsessive Compulsive Disorder (OCD) in severe form. This could be pseudo-obsessions as part of the schizophrenia disorder, or it could be an adverse effect of clozapine*”.⁹⁷

- 2.119 Professor Nielssen opined that clozapine may have exacerbated Mr Cauchi's OCD symptoms (noting Mr Cauchi was reported to have OCD symptoms prior to clozapine commencement, and a return of certain fears after he ceased clozapine treatment).⁹⁸ Professor Nielssen also commented that it is very hard to separate OCD and schizophrenia and “*I think it's just part of the one syndrome*”.⁹⁹

⁹³ Transcript, D16 (Heffernan): T1472.12-32 (22 May 2025).

⁹⁴ Transcript, D16 (Nielssen): T1398.50-T1399.7 (22 May 2025).

⁹⁵ Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [2.2], [2.4.5], [4.1].

⁹⁶ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [2.15].

⁹⁷ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [18].

⁹⁸ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [127].

⁹⁹ Transcript, D16 (Nielssen): T1400.17, T1400.22-24 (22 May 2025).

- 2.120 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.

Clozapine levels are gradually reduced

- 2.121 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 2018.¹⁰⁰
- 2.122 The expert psychiatrists were not critical of Dr Boros-Lavack's decision to reduce Mr Cauchi's clozapine dose.
- 2.123 The first dose decrease under Dr Boros-Lavack's care was from 550mg to 525mg nocte on 10 April 2012.¹⁰¹ On that date, Dr Boros-Lavack wrote to Dr Grundy, including to say that Mr Cauchi *"would like to see how he goes on decreased dose of Clopine"*.¹⁰²
- 2.124 On 28 April 2012, Mr Cauchi graduated from the University of Southern Queensland with a Bachelor of Arts with Distinction (with Majors in International Relations and Language and Culture).¹⁰³ He required assistance to complete that degree over an 11-year period, from his lecturers and his mother.¹⁰⁴
- 2.125 On 16 or 17 January 2013, a note (seemingly of Dr Boros-Lavack) recorded amongst other things: *"testing optimum dose. No other reason"*.¹⁰⁵ Dr Boros-Lavack wrote to Dr Grundy on that date, advising that: *"Joel is doing very well and wanting to reduce the dose of his Clopine to find his optimum dose"*.¹⁰⁶
- 2.126 On 9 April 2013, Mr Cauchi's clozapine concentration was 290 micrograms per Litre (ug/L).¹⁰⁷ Test results from around this time refer to a reference range of 400-1000 ug/L and state that: *"Therapeutic response is likely at clozapine concentrations above 400 ug/L while levels above 1000 ug/L may cause seizures."*¹⁰⁸
- 2.127 Dr Boros-Lavack gave evidence that from April 2013, that level *"was subtherapeutic (i.e. less than 400 ug/l)"*¹⁰⁹ and that:

The Clozapine doses he was taking from 2013 until 2018 were not likely to have had antipsychotic efficacy, because the levels were sub-therapeutic (a reduced dose that

¹⁰⁰ See: Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 40-77.

¹⁰¹ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [5].

¹⁰² Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [5]; Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 225.

¹⁰³ Exhibit 1, Vol 23, Tab 864, University of Southern Queensland, Academic Transcript at p. 1.

¹⁰⁴ Exhibit 1, Vol 22, Tab 812, Statement of Dr Frank Golik at p. 6; Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [30].

¹⁰⁵ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 103.

¹⁰⁶ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 230.

¹⁰⁷ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at pp. 125, 245.

¹⁰⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 262.

¹⁰⁹ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [24].

*it is unlikely to have any therapeutic or beneficial impact, or only a possible minor therapeutic beneficial impact, beyond any placebo effect).*¹¹⁰

2.128 Counsel Assisting submitted that the expert psychiatrists, other than Professor Large, did not agree with Dr Boros-Lavack's view that Mr Cauchi's clozapine dose from April 2013 could be described as "sub-therapeutic".¹¹¹ The psychiatrist experts indicated that even very low doses of clozapine can still be effective for management (although Professor Harris opined that Mr Cauchi's clozapine dose was "*likely to have been ineffective for a prolonged period of time*").¹¹²

2.129 Counsel Assisting submitted: "*It's true that at some point it would have become subtherapeutic, but it's certainly not as easy to determine when, and not possible to say that it was ineffective from as early as 2013 and 2014*" and that Mr Cauchi was never free of negative and cognitive symptoms, or of OCD, from 2014 to 2018. Relatedly, Counsel Assisting submitted that Dr Boros-Lavack's evidence that Abilify 5mg was a sub-therapeutic dose is confusing when that is the dose she says she put Mr Cauchi on in 2019 when concerned about a relapse.¹¹³

2.130 Counsel for Dr Boros-Lavack submitted in oral submissions as follows:

Your Honour heard that the weaning process was gradual, measured, highly conservative in the circumstances. Whereover at least from the period 2015 to 2018, the quantity, the dosage of the clozapine medication was way below any therapeutic drug level, and whatever efficacy it achieved in combination with the low dose of Abilify, it gave ample opportunity for Dr Boros-Lavack to assess whether or not [Mr Cauchi] was responding favourably to the reduction in the dose. The dose reduced eventually, from what was in the public mental health system I think 600 or 500 milligrams a day, was reduced eventually by 2017 and 2018 to 50 milligrams a day and then 25 milligrams a day, so an insignificant dose of the antipsychotic. That enabled Dr Boros-Lavack to assess whether it was a suitable trial to pursue or not, and it, as the experts agreed, was a suitable mechanism to assess whether he was doing well or not under that reduced dosage regime.

*Indeed, all the evidence suggests he was doing well, even though he had the benefit, still, of the low dose of the clozapine until mid 18 [2018] and then a very low dose of Abilify until mid 2019. ...*¹¹⁴

2.131 In terms of whether Mr Cauchi's medication doses were sub-therapeutic, 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.

¹¹⁰ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [15].

¹¹¹ See: Transcript, D16 (Nielssen/Heffernan/Harris/Nordentoft/Large): T1424.5-T1427.48; Written submissions of Counsel Assisting at [201]-[202].

¹¹² Transcript, D16 (Harris): T1425.16-24 (22 May 2025); Written submissions of Counsel Assisting at [201].

¹¹³ Transcript, Closing Submissions D1: T1906.13-30 (25 November 2025).

¹¹⁴ Transcript, Closing Submissions D2: T1985.39-T1986.8 (28 November 2025).

- 2.132 This may have been another aspect of Dr Boros-Lavack's confirmation bias in that she thought the medication was having no effect, in circumstances where it was.
- 2.133 As at January 2015, Mr Cauchi was observed by Mi-Mind Centre staff to have a "bizarre" walk, involving watching the floor. Dr Boros-Lavack did not consider there to be OCD or a pathological mental state. The plan recorded included to obtain a second opinion from Dr Nicky Stephens (the psychiatrist who had commenced Mr Cauchi on clozapine in 2002).¹¹⁵

Second opinion (2015)

- 2.134 On 6 May 2015, Dr Boros-Lavack wrote a letter to Dr Grundy requesting that Mr Cauchi be referred to Dr Stephens for a second opinion. The letter included:

*With the advent of Nicky coming to Private Practice I've approached her to give a second opinion regarding Clopine. What would be his optimum dose; could we switch him to another medication e.g. optimum dose of Abilify (note this was introduced for Clopine induced OCD). I do believe Joel needs an antipsychotic for long term relapse prevention.*¹¹⁶

- 2.135 Counsel Assisting submitted it is clear that Dr Boros-Lavack's intention (with respect to the above letter) was that Mr Cauchi continue on some form of antipsychotic medication, which was needed for long-term relapse prevention.¹¹⁷
- 2.136 On 14 July 2015, Dr Stephens saw Mr Cauchi. Dr Stephens' letter to Dr Boros-Lavack of the same date referred to discussing "stopping" clozapine and included the following:¹¹⁸

- (a) Dr Stephens had "discussed with Joel and his mother today the potential risks and benefits of stopping clozapine medication. The risks of relapse of positive symptoms and also potential exacerbation of negative symptoms and the attendant impairment in functioning and disruption to his ongoing study and lifestyle. The benefits of a trial off clozapine would be to reduce the ongoing risks of potential side effects such as neutropaenia [sic], cardiac side effects, and metabolic syndrome and to determine whether his illness is manageable on a less complex antipsychotic medication such as aripiprazole for the longer term";
- (b) On balance, Mr Cauchi wanted to proceed with trialling a further slow reduction of his clozapine dose;
- (c) Mr Cauchi had agreed that if there were any early warning signs of psychosis, reduction would have to be abandoned and a return to a slightly higher dose of clozapine would most likely be the recommendation; and

¹¹⁵ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 92.

¹¹⁶ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 67; Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 287.

¹¹⁷ Transcript, Closing Submissions D1: T1901.44-46 (25 November 2025).

¹¹⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 234-235.

(d) *“His mother was agreeable to support him through this time and in view of Joels limited recollection of his positive psychotic symptoms, the family are most likely to be the people to recognise any early signs of relapse”.*

2.137 On 29 July 2015, Dr Boros-Lavack noted that Mr Cauchi was doing extremely well and that: *“[s]econd opinion by Dr Stevens [sic] confirmed the same and suggested slow reduction of Clopine. Continue to cut down Clopine with 25mg/d every 3-6 months...”*.¹¹⁹

2.138 In oral evidence, Dr Boros-Lavack stated that at the time of seeking Dr Stephens' second opinion, the goal was to find the optimum dose of clozapine and not to ultimately cease clozapine, and that although Dr Stephens' letter referred to a *“trial off clozapine”* they did not discuss that.¹²⁰

2.139 Counsel Assisting submitted with respect to the period from 2012 to 2015:

*In general, the three years of treatment for Mr Cauchi from 2012 to 2015 were relatively stable. Dr Boros-Lavack continued to titrate the dose of clozapine down, and Mr Cauchi continued to attend Mi-Mind to see the nursing staff and Dr Boros-Lavack on a (roughly) monthly basis. His parents, and particularly Michele Cauchi, remained highly involved in his care, and were his primary social supports. However, Mr Cauchi's negative symptoms continued unabated; he remained unemployed and was socially isolated.*¹²¹

2.140 The experts are not critical of Dr Boros-Lavack's care from 2012 to 2015, when Mr Cauchi's clozapine dose was being titrated down. Overall, it seems the care provided in terms of medication was very good, although ideally it would have been best if Mr Cauchi had access to a multi-disciplinary team and allied health (particularly occupational therapists and psychologists) to help with his functioning, as opined by Professor Harris. Mr Cauchi's care also occurred with the support of Mrs Cauchi and a second opinion in this period.

2.141 Counsel Assisting submitted that at some time between July 2015 and June 2019, Dr Boros-Lavack's plan (to find the optimum dose of clozapine or exchange clozapine for another antipsychotic) changed.¹²²

Treatment from 2016 to 2018 (including cessation of clozapine)

2.142 From 2016 to 2018, Mr Cauchi's clozapine dose continued to be gradually reduced.¹²³

2.143 From 2016 to 5 March 2019, upon referral from Dr Grundy, Mr Cauchi saw private psychiatrist, Dr Joanne Barkla (who was not based at the Mi-Mind Centre) on seven

¹¹⁹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 66.

¹²⁰ Transcript, D11 (Boros-Lavack): T916.49-T925.48 (13 May 2025).

¹²¹ Written submissions of Counsel Assisting at [212].

¹²² Transcript, Closing Submissions D1: T1902.5-13 (25 November 2025).

¹²³ For example, Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 224-227.

occasions, for the purpose of “Bio Balance”.¹²⁴ She did not manage Mr Cauchi’s schizophrenia. Dr Barkla describes Mr Cauchi as a “*polite, reserved, quietly spoken man, who was describing clear goals to pursue his studies and eventually work as an interpreter*”.¹²⁵

- 2.144 Counsel for Dr Barkla adopted as accurate aspects of Counsel Assisting’s written submissions with respect to her care of Mr Cauchi.¹²⁶ Dr Barkla is not an interested party in this Inquest, and her care of Mr Cauchi is not an issue being explored.
- 2.145 On 7 April 2017, Mr Cauchi graduated with a Diploma of Arts from the University of Southern Queensland. He completed that over a three-year period and gained a High Distinction result in all six subjects (which were related to language).¹²⁷
- 2.146 In April 2018, Mr Cauchi requested to remain on a low dose of clozapine as he was finding it difficult to cease clozapine. On 31 May 2018, Mr Cauchi indicated to RN Brooks that he wanted to cease clozapine. He also saw Dr Boros-Lavack that day, who recorded a plan to stop clozapine 12.5mg nocte. However, Mr Cauchi continued to take clozapine 12.5mg for a further month as he was going on holiday.¹²⁸
- 2.147 Mr Cauchi last took clozapine on 28 June 2018.¹²⁹
- 2.148 The “Therapy event/Termination of treatment” form completed by Dr Boros-Lavack on 28 June 2018 recorded under “*Ceased due to medical reasons (not listed above)*”: “*Recovered from 1st episode psychosis and remained well with no relapse over the past 16 years!*” and that there had been no precipitating event “*except discontinuation of Clopine due to successful treatment*”.¹³⁰
- 2.149 Counsel Assisting submitted:
- The suggestion that there had been no relapse over those 16 years is not correct. The suggestion that is made in that letter of a recovery from first episode psychosis with no relapse over the past 16 years is simply not correct, and it misrepresents the true extent of Joel's illness.*¹³¹
- 2.150 As per the expert opinion, Mr Cauchi did appear to have negative and positive symptoms. For instance, Professor Large opined that when Mr Cauchi was discharged from the public system in 2012, Mr Cauchi had been stabilised on large doses of clozapine but still experienced some positive signs of psychosis and negative symptoms of schizophrenia.¹³²

¹²⁴ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at pp. 314-315; Exhibit 1, Vol 21, Tab 794, Statement of Dr Joanne Barkla at [9], [17]; Exhibit 1, Vol 21, Tab 795, Barkla Medical medical records at pp.1-99.

¹²⁵ Exhibit 1, Vol 21, Tab 794, Statement of Dr Joanne Barkla at [18], [23].

¹²⁶ Written submissions on behalf of Dr Grundy, Dr Ruge, Dr Parkar and Dr Barkla at [8].

¹²⁷ Exhibit 1, Vol 23, Tab 864, University of Southern Queensland, Academic Transcript at pp. 1-2.

¹²⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 39-42.

¹²⁹ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [29].

¹³⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 170.

¹³¹ Transcript, Closing Submissions D1: T1902.27-32 (25 November 2025).

¹³² Transcript, D16 (Large): T1405.9-15 (22 May 2025).

2.151 Importantly, Dr Boros-Lavack's termination of treatment form dated 28 June 2018 referred to Mr Cauchi's clozapine being ceased because of "*successful treatment*", which indicates that Dr Boros-Lavack considered Mr Cauchi had recovered at that time. This was probably the beginning of Dr Boros-Lavack's confirmation bias with respect to Mr Cauchi's schizophrenia having been successfully treated.

2.152 I address the decision to cease Mr Cauchi's clozapine later in this section.

Events after Mr Cauchi moved out of the family home

2.153 On 19 November 2018, Mr Cauchi moved out of his family home for the first time, into a nearby unit in Toowoomba. Mrs Cauchi describes that Mr Cauchi required support as he could not look after himself.¹³³

2.154 On 28 November 2018, Mrs Cauchi called the Mi-Mind Centre and indicated that she was concerned, including because Mr Cauchi was outside of the home too much.¹³⁴

2.155 On the same date, Dr Boros-Lavack saw Mr Cauchi and made a note that he presented well "*but also vulnerable*" and he was "*very busy with his newly acquired independence*". Dr Boros-Lavack also noted:

*Mental state was apsychotic, euthymic, but exhausted with a new mannerism or complex tick [sic] of frowning towards right then bringing his gaze back into the conversation like he was responding to a NAS [possibly meaning "Non apparent stimulus"]. When confronted, he was grateful for it, and explained his behaviour of fighting with breaking down emotionally then cried with head down from exhaustion, as he has been well aware of doing too much. Taking Abilify 5mg mane [morning]. Requested a blood test to check his LFTs [Liver Function Tests]. Responded well to counselling.*¹³⁵

2.156 The expert psychiatrists opined that they could not be certain as to whether the tics on 28 November 2018 reflected a psychotic process.¹³⁶

2.157 Counsel Assisting submitted that with the benefit of hindsight, the note of 28 November 2018 "*may be the first indication that Mr Cauchi was experiencing the early warning signs that should have triggered very careful review by Dr Boros-Lavack...*" (including discussion with Mr Cauchi's close family members as to what they were observing and feedback to the family and GP) and that "*Dr Boros-Lavack failed to monitor Mr Cauchi as closely as she should have done following these reports*".¹³⁷

¹³³ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [31]-[32].

¹³⁴ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 35.

¹³⁵ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 36.

¹³⁶ Transcript, D16 (Heffernan): T1427.31-41 (22 May 2025); Transcript, D16 (Harris/Nielssen): T1427.43-48 (22 May 2025); Transcript, D16 (Large): T1428.5-30 (22 May 2025); Transcript, D16 (Harris): T1428.45-T1429.5 (22 May 2025); Transcript, D16 (Nordentoft): T1429.26-28 (22 May 2025).

¹³⁷ Written submissions of Counsel Assisting at [260]; Transcript, Closing Submissions D1: T1909.8-10 (25 November 2025).

- 2.158 Counsel Assisting submitted that Dr Boros-Lavack (in her oral evidence) indicated that ceasing Abilify improved Mr Cauchi's tics to an extent, however:

*That evidence appears to minimise the symptoms of tics that had been recorded in the notes of 28 November 2018 as "new mannerism and complex tick". This was not a "residual complex tic, but rather a new mannerism that should have been given attention, to determine whether it was a possible early warning sign signalling deteriorating mental health. Dr Boros-Lavack needed to pay more careful attention. The explanation for her failure to do so may be because she lacked the knowledge or care or was working an excessive number of hours and could not provide each patient with the attention they deserved. Given the lack of reflection by Dr Boros-Lavack during her evidence at inquest, the cause of the poor practice is harder to identify.*¹³⁸

- 2.159 It is submitted on behalf of Dr Boros-Lavack that the above criticism is unwarranted and that Counsel Assisting's submissions do not refer to evidence in support of it.¹³⁹
- 2.160 In terms of Mr Cauchi's tics at this time, 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.

Treatment from 2019 to 2020

Cessation of all antipsychotic medication in June 2019

- 2.161 On 13 February 2019, Mr Cauchi advised Dr Boros-Lavack that he would like to stop taking Abilify later that year. The plan included: "*May stop Abilify 5mg mane in mid year (after his birthday)*".¹⁴⁰
- 2.162 On 14 March 2019, Mr Cauchi saw Dr Grundy who noted: "*Requests plan to access Psychology to get some counselling[sic]. Checking out options. Will think about this*".¹⁴¹ There is no evidence Mr Cauchi did see a psychologist after this point.
- 2.163 On 15 May 2019, Dr Boros-Lavack recorded that Mr Cauchi wanted to cease Abilify and the plan was to meet in a month with Mrs Cauchi to discuss that.¹⁴²
- 2.164 On 12 June 2019, Dr Boros-Lavack saw Mr Cauchi, with Mrs Cauchi present. Dr Boros-Lavack recorded that Mrs Cauchi agreed Mr Cauchi had been totally well since he ceased clozapine and the only issue he experienced was residual complex tics. The plan

¹³⁸ Written submissions of Counsel Assisting at [271].

¹³⁹ Written submissions on behalf of Dr Andrea Boros-Lavack at [19.11]-[19.14].

¹⁴⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 34.

¹⁴¹ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 4.

¹⁴² Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 32, 156-159.

recorded by Dr Boros-Lavack was: *“collaboratively decided to stop Abilify 5mg mane, continue with no psychotropics at all. ... Continue with timely follow up”*.¹⁴³

- 2.165 The evidence suggests Mr Cauchi did not commence any psychotropic medication after this time. This was approximately five years prior to his death.
- 2.166 With respect to the decision to cease Abilify, Dr Boros-Lavack's evidence included the following:
- (a) Mr Cauchi ceased Abilify *“uneventfully”* and *“it was discontinued with shared decision on 12 June 2019, as it was deemed not feasible considering the benefits versus the harms of continuing treatment”*;¹⁴⁴
 - (b) Apart from Mr Cauchi's desire to cease Abilify, the rationale for cessation was based on his continued clinical stability and improvement (after clozapine cessation), and continued remission of symptoms despite slow dose reductions. Dr Boros-Lavack states the Abilify was always at a low, subtherapeutic level;¹⁴⁵ and
 - (c) *“On 12 June 2019, his Abilify 5mg mane was stopped due to successful treatment. While schizophrenia is a chronic illness with risk of relapse, in Joel's case the cessation of his antipsychotic medications was a reasoned and evidence-informed clinical decision made in good faith, and in accordance with best practice with continuing long term mental health care”*.¹⁴⁶

Decision to cease Mr Cauchi's antipsychotic medications

- 2.167 I will address the decision to cease Mr Cauchi's clozapine (which Mr Cauchi last took on 28 June 2018) and Abilify (which was ceased on 12 June 2019) together in this section.
- 2.168 According to Dr Boros-Lavack: *“[t]he consideration to cease Mr Cauchi's psychotropic medication occurred gradually over the course of deprescribing his Clozapine between 13 March 2012 and 31 May 2018”*. Dr Boros-Lavack in her oral evidence did not accept the proposition that it was necessary to seek a second opinion at the time of stopping either clozapine or (later) Abilify.¹⁴⁷ Dr Boros-Lavack also gave evidence as follows in this issue:
- (a) *“Joel was very patient, thoughtful and cooperative during the collaboratively therapeutic venture of slow dose reduction of Clozapine. During the slow Clozapine dose reduction regime Joel's negative and cognitive symptoms of schizophrenia fully remitted without any relapse of his positive symptoms. Simultaneously Joel's personality deficits due the [sic] adolescent onset of his*

¹⁴³ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 31, 115.

¹⁴⁴ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [127], Answer 6.1, 6.5.

¹⁴⁵ Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at p. 5; Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [17], [21].

¹⁴⁶ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [12].

¹⁴⁷ Transcript, D11 (Boros-Lavack): T916.49-T925.48 (13 May 2025).

*schizophrenia, which negatively interfered with his adolescent and young adult personality development, were not just repaired by catching up with his developmental delays along the remission of his secondary negative and cognitive symptoms but his personality started to show continuous improvement and growth. With the shared knowledge and experience of Joel improved symptomatology and personality development on the slowly decreasing doses of Clozapine during his ongoing psychiatric care we collaboratively decided to continue deprescribing his Clozapine, which he completed over 6 years of treatment between 13 March 2012 and 31 May 2018”;*¹⁴⁸ and

- (b) *“On 28 June 2018, Joel’s Clozapine / Clopine was discontinued for his first episode schizophrenia following a sustained period of clinical stability and functional recovery due to his preference and side effect burden. The decision was made after comprehensive review of his good progress with sustained full recovery and risks, in line with evidence-based practice, and current evidence supporting careful cessation in select cases where long term remission is sustained, and the risks of ongoing Clozapine therapy (haematological monitoring and side effect burden) outweigh the benefits. The cessation was planned and supervised, and the treatment was considered successful in managing his illness”.*¹⁴⁹

2.169 The evidence of the expert psychiatrists, with respect to the decision to reduce and ultimately cease clozapine and Abilify, included this:

- (a) Professor Nielssen opined that in hindsight, the decision to cease clozapine was a mistake. Professor Nielssen did not disagree with the decision to trial the removal of clozapine, which was in accordance with Mr Cauchi’s wishes, although noted that ideally Mr Cauchi needed close monitoring from the points in time when he ceased clozapine and then Abilify, given the risk of relapse. Professor Heffernan and Professor Harris agreed.¹⁵⁰
- (b) Professor Harris would have preferred for Mr Cauchi to remain on clozapine at a dose of 300-400mg per day, augmented by a low dose of aripiprazole (such as the 5mg he was taking), although Professor Harris opined that the decision to trial cessation of Mr Cauchi’s medication was not unreasonable.¹⁵¹
- (c) Professor Harris also gave evidence 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. Professor

¹⁴⁸ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [127], Answer 6.4.

¹⁴⁹ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [12].

¹⁵⁰ Transcript, D16 (Nielssen): T1424.5-31 (22 May 2025).

¹⁵¹ Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [4.2]-[4.4].

Heffernan, Professor Nielssen and Professor Nordentoft generally agreed with that opinion.¹⁵²

- (d) Professor Nordentoft gave evidence that whilst most guidelines would recommend long-term medication for someone in Mr Cauchi's situation (rather than discontinuation):¹⁵³

Nevertheless, he wanted to get off medication, and at the time when he expressed that wish, he was not psychotic. It cannot be ruled out that it would have been possible to persuade him to continue with 5 mg aripiprazole, particularly if he had continued to have consultations with the psychiatrist he had consulted for nine years. In the case of discontinuation after many years of treatment for treatment resistant schizophrenia, careful follow-up to detect signs of relapse should be carried out ...

...

[A]lthough there must have been a considerable risk of relapse, it can be justified to take Mr Cauchi off antipsychotic medication in June 2019. ...

- (e) Professor Heffernan commented in his expert report that:¹⁵⁴

- i. *"I gather from the documentation that Dr Boros-Lavack found herself on a treatment trajectory that inadvertently led to cessation of clozapine, and I assume that this was not the intent at the commencement of the dose reduction"; and*
- ii. *It was "necessary to be clear about the end point: dose reduction versus cessation. If cessation was the end point an alternative medication treatment plan should have been introduced. TRS [treatment resistant schizophrenia] is a chronic relapsing, remitting brain disorder and usually requires life-long care and treatment, including antipsychotic medication".*

- (f) Professor Large's evidence included that it was very reasonable and ordinary practice for Dr Boros-Lavack to gradually reduce Mr Cauchi's clozapine dose, that the decision to cease Mr Cauchi's antipsychotic medications was within the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) guidelines, and that Dr Boros-Lavack monitored Mr Cauchi closely for around 18 months after ceasing clozapine.¹⁵⁵

¹⁵² Transcript, D16 (Harris/Heffernan/Nielssen/Nordentoft): T1392.9-T1393.27 (22 May 2025).

¹⁵³ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [83], [86].

¹⁵⁴ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [4.4], [4.6].

¹⁵⁵ Exhibit 1, Expert Volume, Tab 12, Expert Report of Professor Matthew Large at [222]-[225], [228], [229]-[233], [236].

- 2.170 Counsel Assisting submitted that the decision to cease clozapine was, with hindsight, an error, although that I would not be critical of Dr Boros-Lavack for trialling cessation of clozapine as it was not contrary to any policy or guideline.¹⁵⁶
- 2.171 Counsel Assisting submitted that the issues regarding the cessation of antipsychotic medication included: there was no record of a comprehensive explanation of the high risk of relapse after ceasing medication or the signs and symptoms to look out for;¹⁵⁷ Dr Boros-Lavack did not provide adequate guidance as to the high risk of relapse (and should have had a high index of suspicion that Mr Cauchi would relapse, which became much more pronounced from October 2019);¹⁵⁸ it does not appear Mr Cauchi or Mrs Cauchi were agitating for him to cease clozapine and he was led down that path by Dr Boros-Lavack;¹⁵⁹ there was little focus on Mr Cauchi's reported significant fatigue;¹⁶⁰ and there was no justification for suggesting Mr Cauchi's negative and cognitive symptoms had entirely abated.¹⁶¹
- 2.172 It was submitted on behalf of Dr Boros-Lavack that the unanimous expert opinion was that Dr Boros-Lavack's decision to gradually reduce Mr Cauchi's clozapine dose, and then cease Mr Cauchi's antipsychotic medication (in line with Mr Cauchi's wishes and supported by Mrs Cauchi), was an acceptable and responsible decision.¹⁶²
- 2.173 Further, it was submitted on behalf of Dr Boros-Lavack that Dr Boros-Lavack was insistent in her evidence that she regularly discussed early warning signs of relapse, and that the absence of a written note regarding risk is an inadequate basis to form a positive finding that Dr Boros-Lavack failed to provide adequate guidance regarding risk of relapse.¹⁶³
- 2.174 Other submissions regarding Dr Boros-Lavack's care and treatment of Mr Cauchi are set out later in this section (under "Standard of care provided by Dr Boros-Lavack").

Findings

- 2.175 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.
- 2.176 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

¹⁵⁶ Transcript, Closing Submissions D1: T1906.32-37 (25 November 2025); Written submissions of Counsel Assisting at [559].

¹⁵⁷ Transcript, Closing Submissions D1: T1902.15-20 (25 November 2025); Written submissions of Counsel Assisting at [248](a).

¹⁵⁸ Transcript, Closing Submissions D1: T1909.18-23 (25 November 2025).

¹⁵⁹ Written submissions of Counsel Assisting at [248](b).

¹⁶⁰ Written submissions of Counsel Assisting at [248](c).

¹⁶¹ Written submissions of Counsel Assisting at [248](c).

¹⁶² Transcript, Closing Submissions D2: T1977.15-41 (28 November 2025).

¹⁶³ Written submissions on behalf of Dr Andrea Boros-Lavack at [8.1]-[8.8]; Transcript, Closing Submissions D2: T1986.10-19 (28 November 2025).

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.

- 2.177 As noted above, 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.
- 2.178 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 later in this Part.
- 2.179 Professor Large opined that the decision to cease Mr Cauchi's antipsychotic medication was within the RANZCP guidelines.
- 2.180 I accept all of the expert opinions as set out above.
- 2.181 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.
- 2.182 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 Mrs Cauchi.
- 2.183 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 directly below.

Possible signs of mental health decline from October 2019

- 2.184 Counsel Assisting submitted that early warning signs began to emerge for Mr Cauchi probably by the end of 2018, and certainly by October 2019, which was approximately four months after he ceased all antipsychotic medication. Counsel Assisting submitted there were "*significant red flags that pointed to relapse*".¹⁶⁴ The key events from October 2019 are set out below.

¹⁶⁴ Transcript, Closing Submissions D1: T1909.25-29 (25 November 2025).

- 2.185 I pause here to note that I do have concerns regarding Dr Boros-Lavack's management of Mr Cauchi's care from this period of time (October 2019), and concerns that she was impacted by a confirmation bias (that Mr Cauchi was not experiencing a relapse). This is expanded on below.
- 2.186 On 22 August 2019, Dr Grundy saw Mr Cauchi for the final time (which was for a viral illness).¹⁶⁵ Dr Grundy states generally that Mr Cauchi was "*always polite and compliant with all treatment offered*".¹⁶⁶
- 2.187 Counsel Assisting submitted that from at least 17 October 2019 onwards, being approximately four months after ceasing all antipsychotic medication, Mrs Cauchi began raising concerns with the Mi-Mind Centre regarding Mr Cauchi.¹⁶⁷
- 2.188 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 from healthcare providers (other than Mi-Mind Centre) and seemingly to have semen frozen.
- 2.189 On 17 October 2019 at or before 9:21am, Mr Cauchi called the Mi-Mind Centre and cancelled his scheduled appointment for that afternoon, saying he was unwell (although a note of the call recorded "*He did not seem sick ...*"). Mr Cauchi then rang the Mi-Mind Centre again and requested to continue with the appointment. According to a note made by RN Brooks at 11:12am:
- Joels [sic] mother rang admin and reported her concern for his mental health and physical health and she had told Joel to keep the appointment. Mother requested for MHN [Mental Health Nurse] to be aware of Joels current status.*¹⁶⁸
- 2.190 On that date, Dr Boros-Lavack saw Mr Cauchi, with RN Brooks and Mrs Cauchi present. At 2:38pm, Dr Boros-Lavack recorded a note referring to Mrs Cauchi's "*concerns for relapse*". Dr Boros-Lavack recorded that Mr Cauchi had a cold and had been sleeping a bit less with some fatigue but otherwise did not have any early warning signs or symptoms and he felt good mentally with no tics.¹⁶⁹
- 2.191 On 23 October 2019, RN Brooks recorded a note indicating: "*Joels mother reports he has not the skills for independent living and there is scope for peer support for Joel to increase skills for ADLs [Activities of Daily Living] and social support*". The next day, Mr Cauchi agreed to be referred to peer support and a referral was made.¹⁷⁰
- 2.192 On or around 6 November 2019, Mr Cauchi met with a male peer support worker who was employed via the Mi-Mind Centre. Mr Cauchi expressed having sexual urges that he

¹⁶⁵ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 3.

¹⁶⁶ Exhibit 1, Vol 19, Tab 785, Signed letter of Dr Richard Grundy at p. 2.

¹⁶⁷ Written submissions of Counsel Assisting at [277].

¹⁶⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 4-5, 19, 28-29.

¹⁶⁹ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [111]; Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 19, 28-29.

¹⁷⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 28, 143; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [32].

wanted to control as they were contrary to his religion. The records of the peer support work for Mr Cauchi are not contained within the available Mi-Mind Centre records.¹⁷¹

- 2.193 On 7 November 2019, Mr Cauchi saw RN McCullagh at Mi-Mind Centre (in RN Brooks' absence) and indicated he intended to work with the peer support worker to build relationships and overcome sexual concerns and that he experienced sexual dysfunction. Mr Cauchi did not want to elaborate to the RN as he found it uncomfortable to speak to a female about that topic.¹⁷²
- 2.194 On 12 November 2019, Mr Cauchi emailed Mi-Mind Centre's reception (with the title "*Tech ideas*"). In that email, he asked to discuss ideas for a "*porn free phone*" and other devices and said that he would consider seeing a specialist if that was recommended.¹⁷³
- 2.195 The expert psychiatrists generally agreed that the significance of the issue of pornography is that Mr Cauchi wanted help removing access from his devices, suggesting some sort of compulsion, which conflicted with his religious beliefs, which might cause stress. Professor Large and Professor Nordentoft opined that decreased libido is a common side effect of antipsychotic medication and Mr Cauchi may have experienced an emergence of libido once he stopped antipsychotic medication.¹⁷⁴
- 2.196 Counsel Assisting submitted that on reflection, the way this compulsion eventuated for Mr Cauchi over time is "*extremely sad*" particularly noting that Mr Cauchi in 2019 asked for help, was open, and said he was willing to see a specialist about the topic if that was recommended.¹⁷⁵
- 2.197 On 13 November 2019, a Mi-Mind Centre note (seemingly made by the receptionist) records:
- Michelle [sic] rang to say that Joel is very unwell since he came off his medication. She would like him to be reviewed as he was doing so much better when he was on Ambifyl [sic]. I advised I would pass the medication [sic] on. Thx ...*¹⁷⁶
- 2.198 On 14 November 2019, Dr Boros-Lavack and RN McCullagh (in RN Brooks' absence) saw Mr Cauchi. Dr Boros-Lavack's note recorded "*Insomniac. No psychosis*" and that Mr Cauchi accepted a short course of medication for sleep. The note of RN McCullagh included "*Kept looking to side when in conversation | Occasional tic present | Reports moods are good | Denies any psychosis*" and "*Wants to stop use of pornography – opposed to religious beliefs – email noted and discussed, given information on how to block sites*".¹⁷⁷

¹⁷¹ Exhibit 1, Vol 19, Tab 792E, Statement of Evan Magin at [11]-[15], [17]; Exhibit 1, Vol 20, Tab 793A, Response from Mi-Mind Centre at pp. 2-3, 8-9; Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 4; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [32].

¹⁷² Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 27.

¹⁷³ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 142.

¹⁷⁴ Transcript, D16 (Nielsen/Large/Nordentoft): T1430.28-T1432.10 (22 May 2025).

¹⁷⁵ Transcript, Closing Submissions D1: T1910.32-38 (25 November 2025).

¹⁷⁶ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19.

¹⁷⁷ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 4-5, 26-27.

- 2.199 On 20 November 2019 at 8:15am, Mrs Cauchi emailed 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. The email states (emphasis added):

I am contacting you about my son, Joel Cauchi. He isn't doing very well since going off Abilify and I know you thought that it wasn't having any effect but I have noticed a gradual decline in his condition and, judging from notes on paper he has left around the place in the past week, I have a feeling he is now hearing voices etc. He is very distracted, forgetful and the OCD is getting out of hand with him going through half a cake of soap in one shower.

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

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

*Thank you for your help.*¹⁷⁸

- 2.200 On the same date at 1:07pm, RN Brooks (who returned from leave on this date) wrote a nursing note indicating, amongst other things, that there were reports from those known to Mr Cauchi of changes in his behaviour. Her note recorded (emphasis added):

He is having extreme OCD with shoering [sic] and washing himself – using half a cake of soap during one shower. Writing a lot of notes +++ at home and leaving them about – Mother read some notes with some content of under Satanic control, of religious themes, desire for porn with conflict of his religious beliefs and wanting no access to porn sites to prevent temptation leaving his phone with his mother at her home overnight so as not to use phone/internet for porn sites, mother reports he is walking funny change in his gait he reports he is afraid of getting sick and is wearing layers and layers of clothes to prevent himself getting sick he has been observed that he bends his head a lot and has odd movements

*Reports that he very [sic] busy but unsure of what he is doing with his day. Wanting connection and relationship – has spoken with some girls recently
Mother does not want Joel to know that she has raised her concerns of deteriorating mental health with staff*

Possibly hearing voices has been considered

¹⁷⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 141; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [47].

Peer support – has cancelled appts – only had 1 meeting and not engaged making excuses on last 2 visits to The practice office on presentation he asked for coffee/drinks – this was given but ? seen as unusual new behaviour

*Joel has rung the office to check on appointment times and given the information and some time later within day or 2 he has rung again asking for same information with little recognition of having had this conversation already in recent days.*¹⁷⁹

2.201 Later that day (20 November 2019), Mr Cauchi was seen by RN Brooks, with Mrs Cauchi also present. Mrs Cauchi reported concerns including (per nursing notes) “*current signs of deterioration/return of symptoms of psychosis/OCD? Cleaning in shower in ?context of looking at porn and showering excessively using a lot of caked soap*”. The plan recorded by RN Brooks (entered the following day) included that Mr Cauchi “*agrees with re-introduction of psychotropics but desperately [sic] wants to avoid sedation*”, that RN Brooks was to discuss Mr Cauchi with Dr Boros-Lavack, and that Mr Cauchi was to be reviewed again the following day.¹⁸⁰

2.202 With respect to Mr Cauchi’s behaviour reported by Mrs Cauchi on 20 November 2019, Professor Harris opined:

*They - they're - they suggest that he is having a relapse, that he's having changes in his behaviour that suggest not only positive symptoms but a, a relapse of his obsessional symptoms. But also of the movement disorder that is highlighted earlier about – by Professor Heffernan as one of the symptoms of, of psychosis.*¹⁸¹

2.203 Professor Large opined that these were concerning matters requiring further investigation. He also commented that the nurse’s examination of Mr Cauchi on 20 November 2019 was not able to elicit hallucinations or delusions so was “*a bit of an intermediate result*”.¹⁸²

2.204 Counsel Assisting submitted:

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

*Counsel assisting commends that evidence to your Honour and says that it's inescapable that they were signs of relapse. ...*¹⁸³

¹⁷⁹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 25-26; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [47].

¹⁸⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 24-26, 141; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [47]-[48].

¹⁸¹ Transcript, D16 (Harris): T1434.3-7 (22 May 2025).

¹⁸² Transcript, D16 (Large): T1435.35-37 (22 May 2025).

¹⁸³ Transcript, Closing Submissions D1: T1811.46-T1912.4 (25 November 2025).

- 2.205 It was submitted on behalf of the Good, Singleton and Young families (as an example of Dr Boros-Lavack not making appropriate concessions) that Dr Boros-Lavack gave inconsistent evidence regarding the concerning behaviours raised in the email dated 20 November 2019 (including whether or not that was an early warning sign of relapse and evidence of psychosis).¹⁸⁴ This is addressed further below.
- 2.206 The next day, on 21 November 2019, Dr Boros-Lavack recorded a plan at 8:36am to prescribe Mr Cauchi Abilify tablets (10mg, one tablet in the morning). The "Prescription History" in the Mi-Mind Centre records provides "*Abilify | one mane...*".¹⁸⁵ Counsel Assisting submitted that the dose of 10mg is consistent with Dr Boros-Lavack's evidence that she initially did suspect a relapse.¹⁸⁶
- 2.207 In her oral evidence, Dr Boros-Lavack said that recording 10mg was a typographical error she made, and that it was conveyed to Mr Cauchi (and he understood) that he was to take half a tablet per day (that is, 5mg).¹⁸⁷ Counsel Assisting submitted that Dr Boros-Lavack's evidence on this point cannot be reconciled with her earlier evidence that 5mg was a sub-therapeutic dose, or with Mrs Cauchi's letter indicating that Dr Boros-Lavack clearly said to Mrs Cauchi that dosage was not having any effect. Counsel Assisting submitted:

*Either Dr Boros-Lavack did intend 10 milligrams, because she recognised that there had been a relapse, or she intended to give him a dose that she now says was sub-therapeutic and that she regarded at the time as sub-therapeutic. So that evidence is frankly confusing. Professor Harris stated that aripiprazole at 10 milligrams would've been the standard dose to commence for someone with schizophrenia, who was not on medication and who was experiencing what appeared to be relapse. Professor Nordentoft agreed but said 5 milligrams was better than nothing.*¹⁸⁸

- 2.208 Dr Boros-Lavack's oral evidence regarding the dose of Abilify she prescribed to Mr Cauchi on 21 November 2019 included the following (in summary):
- (a) With respect to why the dose of 10mg is recorded in two different locations in the records for 21 November 2019, Dr Boros-Lavack said: "*that note which appears in Genie, it was brought in by the software from the prescription*".¹⁸⁹
 - (b) Dr Boros-Lavack gave evidence that a 5mg daily dose of Abilify is *not* a therapeutic dose, and that whilst it did not have an antipsychotic effect (and is not a sufficient dose for relapse prevention), it could have had an effect on Mr Cauchi's general psychopathology. She said: "*It just would help with anxiety, depression and, and OCD and general psychopathology stuff. Sleep*"¹⁹⁰ (and

¹⁸⁴ Written submissions on behalf of the Good, Singleton and Young families at [4.52]-[4.55].

¹⁸⁵ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 5, 24-25.

¹⁸⁶ Transcript, Closing Submissions D1: T1912.3-9 (25 November 2025).

¹⁸⁷ Transcript, D11 (Boros-Lavack): T950.16-T951.6 (13 May 2025).

¹⁸⁸ Transcript, Closing Submissions D1: T1912.19-25 (25 November 2025).

¹⁸⁹ Transcript, D11 (Boros-Lavack): T951.5-6 (13 May 2025).

¹⁹⁰ Transcript, D12 (Boros-Lavack): T1040.31-32 (14 May 2025).

elsewhere she noted Mr Cauchi did not ever have depression). Dr Boros-Lavack also said that *"Five milligram is almost like a placebo effect in psychosis"*.¹⁹¹

- (c) The average starting dose of Abilify on its own (for a patient with schizophrenia) is 15mg and *"you need to have at least 15 milligram of Abilify to get the neuroleptic threshold"*.¹⁹² She also said that according to literature, 10mg Abilify is a sufficient dose for relapse prevention.¹⁹³
- (d) In terms of the reasons for Dr Boros-Lavack purportedly re-prescribing Abilify at a dose of 5mg, Dr Boros-Lavack gave this evidence:
 - i. *"Because this is what we do, psychiatrists. It's not confirmed as psychosis, but it still has effect on general psychopathology. And that is what it does. It - anxiety, it has effect on mood, it has effect on OCD. So I thought if he start taking it, it might help to alleviate the early warning signs of relapse, but it was not necessary in hindsight"*;¹⁹⁴
 - ii. *"Because he had early warning signs of relapse. And I did not prescribe it in an antipsychotic dose. I, I prescribed it in 5 milligram, what he was taking, to cut the edge of the anxiety and help not to develop the psychosis. Because it wasn't psychosis. You have to understand that it wasn't psychosis"*;¹⁹⁵ and
 - iii. She *"decided to give a prescription of 5 milligram Abilify because that was the last drug we, we, we'd withdrawn, in order to as an insurance policy"*¹⁹⁶ and *"Even when you admit a patient with early warning signs of relapse, they don't give medication straight away"*.¹⁹⁷
- (e) Dr Boros-Lavack disagreed that she had kept Mr Cauchi on Abilify for a year after ceasing clozapine because she considered it had a therapeutic effect, in terms of psychosis. Dr Boros-Lavack said: *"What it could have effect, it could have effect on, on mood, on anxiety levels. But - like a placebo, but nothing else"*.¹⁹⁸
- (f) Dr Boros-Lavack disagreed with the proposition that her evidence as to the effect or non-effect of Abilify 5mg had been inconsistent.¹⁹⁹

2.209 I find that the Mi-Mind Centre records suggest it is more likely that Dr Boros-Lavack intended to prescribe one Abilify 10mg tablet (per day), rather than 5mg daily, on 21 November 2019.

¹⁹¹ Transcript, D12 (Boros-Lavack): T995.46-47 (14 May 2025).

¹⁹² Transcript, D11 (Boros-Lavack): T920.6-7 (13 May 2025).

¹⁹³ Transcript, D12 (Boros-Lavack): T1010.8-9 (14 May 2025).

¹⁹⁴ Transcript, D12 (Boros-Lavack): T1008.15-19 (14 May 2025).

¹⁹⁵ Transcript, D12 (Boros-Lavack): T1010.25-29 (14 May 2025).

¹⁹⁶ Transcript, D12 (Boros-Lavack): T1044.19-21 (14 May 2025).

¹⁹⁷ Transcript, D12 (Boros-Lavack): T1044.29-31 (14 May 2025).

¹⁹⁸ Transcript, D12 (Boros-Lavack): T1008.48-50 (14 May 2025).

¹⁹⁹ Transcript, D12 (Boros-Lavack): T1009.2-4 (14 May 2025).

- 2.210 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.²⁰⁰ 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.
- 2.211 Dr Boros-Lavack did not see Mr Cauchi on 21 November 2019.
- 2.212 On the same date at 11:19am, a note of RN Brooks indicates she saw Mr Cauchi face-to-face on his own. The note recorded (amongst other things) that Mr Cauchi’s parents were advised that “*Joel has a script for Abilify but he chosen [sic] not to have it filled at this time*”; Mr Cauchi Snr became adamant he did not want his son to go on medication as it would kill him; Mr Cauchi was “*unable to directly to answer [sic] questions, long wordy replies skirting answer | some facial tic some glances to his right*”; and “*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.*”²⁰¹
- 2.213 Counsel Assisting’s submissions provide that Dr Boros-Lavack gave oral evidence that:
- ... she re-prescribed Abilify for Joel, because she did think at the time that there were, or possibly were, early warning signs of relapse, but that she later believed that the early warning signs of relapse resolved once Joel's fear of contracting a sexually transmitted disease resolved, and she said that it was ultimately her belief that it was not an early warning sign of relapse. It was based on fear of an STD and sexual frustration.*²⁰²
- 2.214 Also on 21 November 2019, Mr Cauchi attended GP, Dr Susan Dragone at St Andrews Medical Centre in Toowoomba for STI screening and appeared “*anxious*”. Later that evening, Mr Cauchi attended the Toowoomba Hospital Emergency Department for concerns of HIV exposure and was referred to a sexual health clinic.²⁰³ On 22 November 2019, Mr Cauchi was prescribed and supplied an antiretroviral medication that can be used to treat and prevent HIV/AIDS (possibly at that sexual health clinic).²⁰⁴ On 25 November 2019, Dr Dragone saw Mr Cauchi again. His STI screen from 21 November 2019 was negative. After the consultation, Mr Cauchi appears to have called the GP practice and requested a medication to prevent STIs and a referral to Queensland Fertility Group for semen freezing.²⁰⁵ Dr Dragone counselled Mr Cauchi about semen

²⁰⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 5-8.

²⁰¹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 5, 24-25; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [47]-[48].

²⁰² Transcript, Closing Submissions D1: T1912.44-50 (25 November 2025).

²⁰³ Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 2-4; Exhibit 1, Vol 19, Tab 789, Metro North Health medical records; Exhibit 1, Vol 26, Tab 949, PBS Claims History for period dated 1 January 2000 – 21 December 2019 at p. 9.

²⁰⁴ Exhibit 1, Vol 17, Tab 784, Toowoomba Base Hospital records (Part 2) at pp. 2-4; Exhibit 1, Vol 19, Tab 789, Metro North Health medical records; Exhibit 1, Vol 26, Tab 949, PBS Claims History for period dated 1 January 2000 – 21 December 2019 at p. 10. Note: The medical records for this sexual health clinic are not in the brief of evidence.

²⁰⁵ Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at pp. 2-3.

freezing not usually being necessary (for someone in his circumstances) and being expensive, however she provided a private referral at his request.²⁰⁶

2.215 On 28 November 2019, Mr Cauchi had semen collected for freezing through Queensland Fertility Group. A note records: “*Patient Very Odd to Deal with*”.²⁰⁷

2.216 Also on 28 November 2019, Dr Boros-Lavack and RN Brooks saw Mr Cauchi. According to a note made by Dr Boros-Lavack that day (emphasis added):

*Mum was contacted by telephone, who told Joel to restart Abilify for relapse prevention based on his EWSR. Joel presented well today. Feeling good with good sleep and no fatigue. Going to Caloundra to have a holiday with his male cousin tomorrow. Not 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. FU with Brooksy b/f xmas and I in Jan. Keen to restart PSW [possibly peer support work] from mid-Jan 2020.*²⁰⁸

2.217 There is no evidence suggesting that Mr Cauchi took Rexulti at any stage.²⁰⁹ In the notes of Dr Boros-Lavack, reference to “EWSR” appears to be shorthand for “early warning signs of relapse”.

2.218 In relation to the events on 28 November 2019, Dr Boros-Lavack stated (in addition to her oral evidence on the topic):

- (a) The trial packs of Rexulti were provided to Mr Cauchi “*to start should he experience early warning signs of relapse;*”²¹⁰ and
- (b) “*... When I reviewed Joel seven days later 28 November 2019, his symptoms had fully resolved without medication. Joel was able to explain his reluctance to take Abilify, which was due to the dysphoric side effect he experienced on it in the past. Joel then accepted a trial pack of Rexulti / Brexpiprazole, the latest form of piprazole atypical antipsychotic with less dysphoric side effect, that he would commence if not feeling well to prevent psychotic relapse. He also agreed to close follow up with us and restart peer-support from next year. Later, Joel disclosed to us that his distress with the early warning signs was related to fear of having contracted an STD. This was fortunately untrue but despite this he decided to take double retroviral treatment for HIV prevention. His fear of contracting HIV appeared to be the cause of his non-psychotic distress.*”²¹¹

2.219 RN Brooks states:

²⁰⁶ Exhibit 1, Vol 19, Tab 786, Statement of Dr Susan Dragone, at [8]-[9.1].

²⁰⁷ Exhibit 1, Vol 22, Tab 797, Queensland Fertility Group medical records at pp. 4, 7-9, 11-13, 24-26.

²⁰⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 24.

²⁰⁹ See, e.g., Exhibit 1, Vol 26, Tab 952, PBS Patient Summary for period dated 1 July 2019 – 13 April 2024.

²¹⁰ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [115].

²¹¹ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [9]-[10].

I recall that in November 2019 Michele Cauchi, Joel's mother, expressed her concerns to me regarding a decline in his mental health and behaviours. I considered Michele Cauchi was well placed to make observations of her son, and I regard her instincts as being alerted to some signs of EWS, however I did not observe these myself.

*I escalated these concerns to Dr Boros-Lavack who adjusted Joel's care plan. Based on his mother's observations we encouraged Joel to recommence his medication for relapse prevention and/or to manage early warning signs. I consider this was appropriate in the circumstances.*²¹²

- 2.220 On 1 December 2019, Mr Cauchi attended a GP at Doctors @ Pacific Fair (on the Gold Coast) and requested prophylactic treatment for HIV. He was prescribed an antibiotic and referred to a sexual health clinic.²¹³ On the same date, Mr Cauchi attended the Gold Coast Hospital and Health Service's ED clinic seeking preventative medication for STIs including HIV (upon referral from that GP). The plan included for the GP to organise an STI screen.²¹⁴
- 2.221 On 3 December 2019, a note seemingly written by the Mi-Mind Centre Practice Manager records that Mrs Cauchi rang and advised that Mr Cauchi's aunt (who he was staying with) found he had a medication used for HIV.²¹⁵
- 2.222 On 4 December 2019, Mr Cauchi called Queensland Fertility Group to report his concerns that his semen collection on 28 November 2019 was contaminated by a lubricant used. Despite enquiries being made with the laboratory which indicated the collection would be adequate, Mr Cauchi "*insisted*" on another collection occurring.²¹⁶
- 2.223 Also on 4 December 2019, RN Brooks spoke to Mrs Cauchi via phone. The note of RN Brooks includes that Mrs Cauchi felt Mr Cauchi was "*very confused*" and Mrs Cauchi remained concerned about him. The plan included that Mr Cauchi was to present for a face-to-face appointment on 19 December 2019 (if not earlier).²¹⁷
- 2.224 The next day, on 5 December 2019, the following occurred per the nursing notes of RN Brooks:²¹⁸
- (a) At 11:11am, RN Brooks recorded a note indicating she advised Mrs Cauchi "*that Joel is to start taking the Rexulti medication today and to consider his compliance and adherence to Drs management*";
 - (b) Mrs Cauchi called Mr Cauchi and told him to call Mi-Mind Centre; and
 - (c) At 11:48am, RN Brooks recorded a note indicating she received a phone call from Mr Cauchi. The note includes (amongst other things) that they discussed

²¹² Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [47]-[48].

²¹³ Exhibit 1, Vol 21, Tab 795B, Letter from Dr Ali Soleymani (GP) at pp. 1-3.

²¹⁴ Exhibit 1, Vol 22, Tab 798, Robina Hospital medical records at pp. 2, 6-22; Exhibit 1, Vol 21, Tab 795B, Letter from Dr Ali Soleymani at pp. 1-3.

²¹⁵ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19.

²¹⁶ Exhibit 1, Vol 22, Tab 797, Queensland Fertility Group medical records at p. 4.

²¹⁷ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 23-24.

²¹⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 22-23.

how he obtained the HIV medication, that he was embarrassed to speak to her and to Dr Boros-Lavack about that, and that RN Brooks *“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.”*

2.225 The note of RN Brooks at 5:20pm on 5 December 2019 records (emphasis added):

Discussed at clinical meeting

Continue with holiday

Encourage start of medications Rexulti, especially if Joel notices any EWS or deterioration.

Continue with his holiday in Brisbane

For phone consult with MHN on Dec 19 if does not return to Twmba and resume F2F appt in January (appt to be made)

Sent a text to Joel with above info

...

P/c to mother to decrease her own anxiety

Informed her currently Joel is managing [sic] well and to continue with his holiday and start med if EWS appears.

Keep appt with MHN

Advise of any issues

Send text messages to Joel as I could not ring him ...²¹⁹

2.226 RN Brooks states that based on earlier conversations with Mr Cauchi and concerns raised by Mrs Cauchi (who was his main carer and familiar with his baseline or optimal mental health), she *“did consider that Joel should recommence taking psychotropic medication on [5 December 2019]”*. In her view, the plan for Mr Cauchi to commence Rexulti on 5 December 2019 did not change over the course of that date (and had been encouraged since 28 November 2019).²²⁰

2.227 However, Dr Boros-Lavack states that:

*Based on the clinical notes of Ms Brooks, the plan regarding recommencement of Rexulti appears to have changed over the course of 5 December 2019. Initially, Mr Cauchi's mother was advised that he should start taking Rexulti that day. However, after Mr Cauchi expressed his desire to discuss this with me as he felt mentally well, I believe I had discussions with Ms Brooks and the plan was adjusted to encourage starting Rexulti if he noticed any early warning signs or deterioration.*²²¹

2.228 Dr Boros-Lavack states that she did not have any conversations with Mr Cauchi or Mrs Cauchi on 5 December 2019.²²²

²¹⁹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 22-23; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [54]-[77]; Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at pp. 1-2.

²²⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 22-23; Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [54]-[77]; Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at pp. 1-2.

²²¹ Exhibit 1, Vol 19, Tab 791, Supplementary Statement of Dr Andrea Boros-Lavack at p. 2.

²²² Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at p. 1.

- 2.229 On 9 December 2019, Mr Cauchi had a further semen collection at Queensland Fertility Group in Brisbane.²²³
- 2.230 On 19 December 2019, Mr Cauchi had a telephone appointment with RN Brooks, whilst still in Brisbane on holiday.²²⁴ This may have been the first time that Mi-Mind Centre became aware that Mr Cauchi was considering moving to Brisbane.
- 2.231 Mr Cauchi was not seen at Mi-Mind Centre between 20 December 2019 and 7 January 2020 (a period of approximately three weeks). The centre was closed for a Christmas break (for an unknown period of time).²²⁵
- 2.232 On 8 January 2020, Dr Boros-Lavack and RN 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.²²⁶
- 2.233 On 28 January 2020, Mr Cauchi sent a Skype message to Dr Snezana Alempijevic (another psychiatrist at Mi-Mind Centre) stating, "*Hey do you do advice for mens sexual performance at all?*". Dr Alempijevic did not respond and advised Dr Boros-Lavack of the message.²²⁷ Professor Heffernan opined this behaviour may be consistent with a psychotic relapse of schizophrenia.²²⁸ Professor Nordentoft considered the message to be inappropriate and a red flag (albeit rather unspecific).²²⁹
- 2.234 On 30 January 2020, RN Brooks called Mr Cauchi as he had requested. Mr Cauchi wanted to know whether clozapine had "*damaged his bodys [sic] temperature system*" or the temperature centre in his brain, as he now felt hotter and colder than he used to.²³⁰
- 2.235 On 12 February 2020, Mr Cauchi attended his final face-to-face appointment at Mi-Mind Centre with RN Brooks. RN Brooks considered there was no evidence of psychosis. Mr Cauchi asked RN Brooks to speak to a therapist about a lack of confidence with sexual knowledge. He was informed there were no such therapists available at that time, and there is no evidence such a therapist was arranged for Mr Cauchi.²³¹
- 2.236 On 14 February 2020, Mrs Cauchi phoned the Mi-Mind Centre to express further concerns regarding Mr Cauchi, including that he was not well and that he may become

²²³ Exhibit 1, Vol 22, Tab 797, Queensland Fertility Group medical records at pp. 14-22.

²²⁴ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 21-22.

²²⁵ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [63], [69]; Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 21.

²²⁶ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 21. See also Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at [117]; Transcript, D11 (Boros-Lavack): T960.30-T963.37 (13 May 2025).

²²⁷ Exhibit 1, Vol 19, Tab 792, Statement of Dr Snezana Alempijevic at [20]-[21]. See also Exhibit 1, Vol 19, Tab 792A, Supplementary statement of Dr Snezana Alempijevic at [2].

²²⁸ Exhibit 1, Expert Vol, Tab 8, Expert Report of Professor Edward Heffernan at [2.29].

²²⁹ Transcript, D16 (Nordentoft): T1432.21-36 (22 May 2025).

²³⁰ Transcript, D10 (Brooks): T861.14-35 (12 May 2025).

²³¹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 20-21.

homeless if he moved to Brisbane. Mrs Cauchi appears to have spoken to the receptionist. The note of that call records:

Michelle [sic] rang to say that Joel is not well and she is worried about him as her husband went around to his flat and said it was a mess and she is worried about him moving to Brisbane as he can't seem to look after himself. He was to see Clare [Schwarz] re Peer Support and he put her off and now he has lost his spot with Peer Support and she said Joel has said that he didn't put her off and that it was only not convenient that day for him. She is worried if he moves to Brisbane he may become homeless.

*Put Michelle [sic] through to Clare for further discussion. ...*²³²

2.237 Mrs Cauchi then spoke to RN Schwarz, who recorded in her note:

Mother Michelle [sic] called to express her concerns about Joels functioning at home and his probable move to Brisbane.

She said that his self care is poor his father went round there to put his bins out and the place was a mess there were dishes in the sink and mess everywhere. She also said that there are renovations happening at his place and that he is staying with them for 2 weeks. He appears more isolated and irritable and is occasionally swearing.

She then said that she did not want Joel to know that she has called, and I said that we can not address these issues with him if that is the case.

Offered joint appointment with myself to discuss these issues, and she said that she did not think that Joel would agree and if he did she does not feel comfortable discussing this as he may get annoyed. When asked what happens when he is annoyed she said he gets irritable and has sworn recently.

I also said that he can be re-referred to peer support program, and advised that there is a waiting list currently.

*Acknowledged her concerns about his self care and she did not have any concerns about his safety.*²³³

2.238 RN Schwarz states she passed Mrs Cauchi's concerns on to Dr Boros-Lavack, and that Mrs Cauchi not wanting Mr Cauchi to know she had called "*made it difficult to address the specific concerns [Michele Cauchi] raised with Joel*".²³⁴

2.239 Dr Boros-Lavack's evidence (in three statements and in oral evidence on 13 and 14 May 2025) was not entirely clear as to whether she considered Mr Cauchi had, or possibly had, "*early warning signs*" of relapse. For example:

- (a) In her oral evidence on 13 and 14 May 2025, Dr Boros-Lavack gave evidence at various stages that Mr Cauchi *did* have early warning signs of relapse.²³⁵

²³² Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 19-20; Exhibit 1, Vol 19, Tab 792C, Statement of RN Clare Schwarz at [21], [25]-[26].

²³³ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 20.

²³⁴ Exhibit 1, Vol 19, Tab 792C, Statement of RN Clare Schwarz at [25]-[27], [30]-[31].

²³⁵ See, e.g. Transcript, D11 (Boros-Lavack): T928.43-46, T944.24-37, T945.44-T946.42, T949.1-20, T951.33-T952.12, T952.35-T953.16, T953.50-T954.6, T955.34-38 (13 May 2025); Transcript, D12 (Boros-Lavack): T1007.17-24, T1010.25 (14 May 2025).

(b) However, her answers on 13 May 2025 also included the following:

- i. *"Q. I take it that even if you had spoken to Sarkar, you wouldn't have raised any concerns for Joel because you didn't think there were any.*

A. No.

Q. Do you agree?

*A. No, I wouldn't have, I wouldn't have raised those early warning signs of relapse, that's correct. Which wasn't an early warning sign of relapse".*²³⁶

- ii. *"Q. Do you think that he did develop a psychosis?*

*A. No. It wasn't the psychosis. It wasn't even early warning signs of relapse. It was based on his fear of STD. It was based on his sexual frustration, what he told us later on, about prostitutes and women and sex".*²³⁷

- iii. *"Q. The third thing that I'm going to suggest to you is wrong with that letter is that there is nowhere in that letter where you refer to the recent concerns expressed by mum, that she thought he might be hearing voices, that she had found satanic notes, that she had noticed changes in his gait?*

*A. No. Because the mother said not to say anything about it, and I was, I was totally, totally relieved that it wasn't a psychotic break and wasn't early warning signs of relapse".*²³⁸

2.240 In any event, after seeing Mr Cauchi, Dr Boros-Lavack determined that the symptoms were unrelated to psychosis, and were the result of Mr Cauchi's fear of contracting an STD.²³⁹

Relapse rate

2.241 Counsel Assisting initially submitted that Dr Boros-Lavack evidently did not understand the true risk of relapse for Mr Cauchi, with reference to the following oral evidence of Dr Boros-Lavack:

Q. You understood, didn't you, taking him off that drug completely, there was more than 50% chance of relapse?

A. I can't tell you that.

Q. You're not sure what—

²³⁶ Transcript, D11 (Boros-Lavack): 976.18-24 (13 May 2025).

²³⁷ Transcript, D11 (Boros-Lavack): 957.34-39 (13 May 2025).

²³⁸ Transcript, D11 (Boros-Lavack): 972.37-43 (13 May 2025).

²³⁹ Transcript, D11 (Boros-Lavack): 974.25-28 (13 May 2025).

A. Maybe, maybe - the relapse is very difficult to, to, to estimate, but we don't - we know that in selected cases, in first episode schizophrenia, they would not relapse at all. Now it is 14% in the literature, that 14% after first episode schizophrenia will relapse. Multi-episode schizophrenia I think more, more vigorous.

...²⁴⁰

2.242 It was submitted on behalf of Dr Boros-Lavack that Counsel Assisting overlooked or misinterpreted the evidence and that Dr Boros-Lavack gave clear evidence that her understanding of the literature was that 14% of patients ceasing antipsychotic medication would *not* relapse (rather than that 14% of patients would relapse).²⁴¹

2.243 It was submitted on behalf of Dr Boros-Lavack, in relation to her above answer, that: *"While that answer is not elegantly phrased, and is somewhat ambiguous, assuming it is accurately recorded, the most likely interpretation is that the category of first episode patients who "would not relapse at all" - is 14%."*²⁴²

2.244 Further, it was submitted on behalf of Dr Boros-Lavack that the alternative interpretation of the above answer would be entirely inconsistent with Dr Boros-Lavack's other oral evidence, in particular these answers:

(a) *"Q. Did you think that there was any risk of relapse when—*

A. Definitely. But I have to tell you, in - when I started my training it was 25% of first episode schizophrenia patients will never relapse. Right now the latest literature shows in very selected cases 14% of the first episode schizophrenic patient would never experience a relapse. So in my mind I was hoping that he was going to belong to this 14%."; and

(b) *"Q. --such as the type you could deliver at the practice, because there would always be a risk of relapse for Joel in certain circumstances?*

*A. Always for the lifetime, but there is 14% of people with first episode psychosis who never have one."*²⁴³

2.245 It was therefore submitted on behalf of Dr Boros-Lavack that it is overwhelmingly clear that Dr Boros-Lavack intended to convey that 14% of patients will *not* relapse, when consideration is given to the three above answers.²⁴⁴

2.246 It was further submitted on behalf of Dr Boros-Lavack that she did have a high index of suspicion for relapse throughout Mr Cauchi's treatment and that Dr Boros-Lavack "was

²⁴⁰ Written submissions of Counsel Assisting at [330]; Transcript, D11 (Boros-Lavack): T921.9-13 (13 May 2025); Transcript, D16 (Large/Harris/Heffernan/Nielssen/Nordentoft): T1392.9-T1393.40 (22 May 2025).

²⁴¹ Written submissions on behalf of Dr Andrea Boros-Lavack at [6.1]-[6.7].

²⁴² Written submissions on behalf of Dr Andrea Boros-Lavack at [6.7].

²⁴³ Written submissions on behalf of Dr Andrea Boros-Lavack at [6.2]-[6.3].

²⁴⁴ Written submissions on behalf of Dr Andrea Boros-Lavack at [6.7].

*hoping that [Joel Cauchi] would be amongst the 14% group of sufferers who would not relapse”.*²⁴⁵

- 2.247 In reply, Counsel Assisting maintained that at one point (that is, in oral evidence on 14 May 2025), Dr Boros-Lavack's evidence suggested that 14% of persons with first episode psychosis would relapse, however accepted that their submissions did not pick up that Dr Boros-Lavack had inconsistently said elsewhere that 14% would *not* relapse. Counsel Assisting submitted that even on re-reading Dr Boros-Lavack's evidence, in terms of whether she did actually understand the risk of relapse, “*it is still not clear*”.²⁴⁶
- 2.248 Ultimately, Counsel Assisting submitted that I should take Dr Boros-Lavack's evidence at its highest, that is, accept she meant to suggest that 14% (of people with first episode psychosis) will *not* relapse (meaning 86% will).²⁴⁷
- 2.249 However, Counsel Assisting submitted that if that is correct, it raises questions as to why Dr Boros-Lavack did not place more weight on Mrs Cauchi's concerns, document an explanation of the risk to Mr Cauchi once symptoms emerged, do more to persuade Mr Cauchi to resume medication, or hand over the risk to Dr Grundy upon discharge. Counsel Assisting also submitted that it would make it more confounding that Dr Boros-Lavack quickly dismissed concerns that she initially thought were early warning signs and that Mr Cauchi should re-commence Abilify.²⁴⁸
- 2.250 It was ultimately submitted on behalf of the Good, Singleton and Young families that it is correct that Dr Boros-Lavack appeared to understand the substantial statistical risk of relapse, however she did not demonstrate an appreciation of that risk in her care of Mr Cauchi and failed to take seriously that she was seeing signs of relapse.²⁴⁹
- 2.251 In terms of Mr Cauchi's statistical chance of relapse, Counsel Assisting submitted that the expert psychiatrists gave evidence that the rate of relapse upon ceasing antipsychotic medication is approximately 90% after two years (and there was consensus amongst those involved in the Inquest that the rate of relapse for a person with treatment resistant schizophrenia after ceasing medication was around 86-90%).²⁵⁰
- 2.252 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.

²⁴⁵ Written submissions on behalf of Dr Andrea Boros-Lavack at [6.3].

²⁴⁶ Transcript, Closing Submissions D2: T2018.49-T2019.36 (28 November 2025).

²⁴⁷ Transcript, Closing Submissions D1: T1907.17-29 (25 November 2025).

²⁴⁸ Transcript, Closing Submissions D1: T1907.24-T1908.22 (25 November 2025).

²⁴⁹ Transcript, Closing Submissions D2: T2008.48-T2009.24 (28 November 2025).

²⁵⁰ Written submissions of Counsel Assisting at [330]; Transcript, D16 (Large/Harris/Heffernan/Nielssen/Nordentoft): T1392.9-T1393.40 (22 May 2025); Transcript, Closing Submissions D2: T2024.29-36 (28 November 2025).

- 2.253 It is clear from what Dr Boros-Lavack said at other times in her evidence, as set out in the submissions on her behalf, 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%.
- 2.254 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.
- 2.255 Dr Boros-Lavack's actions in response to the concerns raised by Mrs Cauchi are dealt with later in these findings.

Discharge from Mi-Mind Centre (2020)

- 2.256 On 17 February 2020, Mr Cauchi attended his final appointment with Dr Boros-Lavack (via Skype, with Dr Boros-Lavack being in Caloundra). Dr Boros-Lavack considered that Mr Cauchi had no signs or symptoms of a psychiatric disorder on this date. During this consultation, they discussed that Mr Cauchi was "*sexually frustrated*" and looking for a casual relationship, a private rental and work in Brisbane. The plan recorded included to continue monitoring and support, for no medication, and for follow-up in one month.²⁵¹ It appears this was the last time that Mr Cauchi saw a specialist mental health clinician on a regular basis.

- 2.257 Dr Boros-Lavack's note dated 17 February 2020 provided:

*Seen on Skype. Well groomed, good hygiene with no tics. Mentally good. No signs/sxs [symptoms] of psychiatric disorder. At his parents house, as his flat is under renovation. People are interested in taking over his lease. Sexually frustrated, as he cant hook up with girl/s at present due to issues with accommodation/privacy. Looking for a casual relationship, a private rental and work in Brisbane. Plan: continue monitoring and support, no meds. FU [follow up] in 1/12 [one month].*²⁵²

- 2.258 Professor Nordentoft (when asked whether it was reasonable to consider that Mr Cauchi was well by 17 February 2020, given the signs that had been indicated) opined: "*I think it is too superficial an evaluation where the mother's concern is not taken into consideration to a sufficient degree*". Counsel Assisting submitted that opinion should be accepted.²⁵³
- 2.259 Counsel Assisting also submitted there was no evidence that on 17 February 2020 there was discussion of Mr Cauchi's previously raised concerns regarding pornography, the hallucinations reported by Mrs Cauchi (which could have been asked about without having to say Mrs Cauchi raised them), or OCD.²⁵⁴

²⁵¹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 20.

²⁵² Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 20.

²⁵³ Transcript, Closing Submissions D1: T1914.27-31 (25 November 2025).

²⁵⁴ Transcript, Closing Submissions D1: T1914.33-39 (25 November 2025).

- 2.260 On 5 March 2020, Mr Cauchi visited a GP at Stafford Skin Cancer Clinic and Medical Centre in Brisbane for the first and only time, requesting screening for STIs.²⁵⁵
- 2.261 On or around 15 March 2020, Mr Cauchi moved from Toowoomba to a share house in Brisbane.²⁵⁶
- 2.262 On 16 March 2020, Mr Cauchi attempted to attend a Skype appointment with Dr Boros-Lavack (as planned, because she was operating from Caloundra).²⁵⁷ However, Mr Cauchi's Skype was not working, as he had "*no sound*".²⁵⁸
- 2.263 Receptionist at Mi-Mind Centre, Desley Hartin states that whilst they were trying to get Mr Cauchi's Skype appointment to work, she had a phone conversation with him and Mr Cauchi advised that he was living in Brisbane. Ms Hartin states: "*Once Joel had moved to Brisbane, he was no longer eligible for the Telehealth appointments with Doctor [Boros-Lavack] as he was living in a metropolitan area*". Ms Hartin spoke to Mr Cauchi on that date "*about his eligibility with Skype appointments, which would have been a brief conversation about him living in Brisbane and would have told him I would need to speak to Doctor Boros-Lavack*".²⁵⁹
- 2.264 The notes in the Mi-Mind Centre records for 16 March 2020 record:²⁶⁰
- (a) "*Living in Brisbane no longer eligible for Skype apts – DH*". It appears this was a note recorded by Ms Hartin following her conversation with Mr Cauchi, to inform Dr Boros-Lavack;²⁶¹ and
 - (b) The following, which is a conversation between Dr Boros-Lavack ("A") and Ms Hartin ("DH"):
- i. "*What will happen with Joel? Who will follow up him unless he comes F2F, A*";
 - ii. "*He is living in Brisbane now and can no longer skype – his skype is not working today he has no sound so we cancelled and then found out he had moved. Need to discuss what you would like to do as he has declined seeing you f2f so do I just refer him back to find a psychiatrist closer to him? He is also not eligible for the nurses program here as he lives in Brisbane. Thx DH*"; and

²⁵⁵ Exhibit 1, Vol 22, Tab 799, Statement of Dr Yuping (Peter) Bai at [4]-[7].

²⁵⁶ See, e.g., Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [37]-[38].

²⁵⁷ See, e.g., Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [30].

²⁵⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19.

²⁵⁹ Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [29], [41]-[44].

²⁶⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19. See also: Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [23]-[26].

²⁶¹ See, e.g., Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [43].

- iii. “ok, refer him back to his new GP in Brisbane, please. He will need to have a new bb-ing [possibly bulk-billing] psychiatrist, or MHS [possibly Mental Health Service] in [Brisbane], Thx, A”.²⁶²

- 2.265 On 17 March 2020, Ms Hartin 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 Mi-Mind Centre when he did.²⁶³
- 2.266 Counsel Assisting notes there is no evidence that Dr Boros-Lavack called Mr Cauchi to sign off or explain her handover, after some eight years of being his psychiatrist.²⁶⁴
- 2.267 At this time, RN Brooks was on a period of leave and as such was not involved in Mr Cauchi’s discharge.²⁶⁵ It appears Mr Cauchi was not allocated to another nurse’s care whilst RN Brooks was on leave.²⁶⁶
- 2.268 On 18 March 2020, Mr Cauchi saw a GP at Cannon Hill Family Doctors in Brisbane for an STI check.²⁶⁷ However, the Mi-Mind Centre records do not indicate that Mr Cauchi advised Mi-Mind Centre of this GP’s details as discussed with Ms Hartin the day prior.
- 2.269 On 19 March 2020, Ms Hartin wrote (using a precedent), and Dr Boros-Lavack signed, a letter to Dr Grundy (whose practice is notably located in Toowoomba and not Brisbane). The letter included the following (emphasis added):

My receptionist has contacted Joel to advise of this change. Joel has indicated that he will be unable to attend face to face appointments with me due to the distance to travel for the appointments.

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

*In the future should Joel move into a Skype eligible area or wishes to see me for face to face appointments I will be happy to, however I will need a new referral for that.*²⁶⁸

- 2.270 That letter was faxed (via an email system) on 23 March 2020 at around 9:00am to Dr Grundy’s practice.²⁶⁹ Dr Grundy initialled the letter, indicating he had read it.²⁷⁰
- 2.271 Dr Grundy states he did not “recall” Mr Cauchi in response to this letter. Dr Grundy states:

²⁶² Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19.

²⁶³ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19. See also Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [45].

²⁶⁴ Transcript, Closing Submissions D1: T1914.41-50 (25 November 2025).

²⁶⁵ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [19], [49].

²⁶⁶ Exhibit 1, Vol 19, Tab 792F, Supplementary statement of RN Andrea Brooks at [1]-[3], [8].

²⁶⁷ Exhibit 1, Vol 22, Tab 801, Cannon Hill Family Doctors medical records at p. 2; Exhibit 1, Vol 22, Tab 801B, Letter from Dr Sandirasegaram Abraham.

²⁶⁸ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 113. See also Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records, at pp. 136-137; Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [36].

²⁶⁹ Exhibit 1, Vol 20, Tab 793B, Response from Mi-Mind Centre at pp. 3-4; Exhibit 1, Vol 19, Tab 785A, Supplementary statement of Dr Richard Grundy at [4]-[5]; Exhibit 1, Vol 19, Tab 792D, Statement of Desley Hartin at [37]-[38].

²⁷⁰ Exhibit 1, Vol 19, Tab 785A, Supplementary statement of Dr Richard Grundy at [8].

I did not recall Mr Cauchi as suggested by Dr Boros-Lavack. I do not now have a memory of having read Dr Boros-Lavack's letter dated 19 March 2020 and my clinical reasoning at that time. Having refreshed my memory by reading Dr Boros-Lavack's letter, I do not understand from her letter that Joel's mental health condition was not stable and/or there was a risk of relapse or other clinical urgency requiring urgent recall of Joel.

During the period I saw Joel, he always made his own appointments at the Practice and was punctual with attending his appointments. He was otherwise compliant with any management plan, including scheduling and attending any follow up consultations as required. There was therefore no evidence of Joel needing chasing up. I therefore would likely have expected Joel to book in for a consultation as required, and did not seek to recall him.²⁷¹

2.272 In terms of Mr Cauchi's discharge from Mi-Mind Centre, Dr Boros-Lavack stated:

- (a) *"Referral to the public mental health service in Brisbane was always an option, however Mr Cauchi had been stable off all psychotropic medications for over 9 months at the time of discharge. He was not experiencing symptoms of psychosis or other mental illness that would have warranted urgent referral to the public system. In addition, Mr Cauchi did not want to go back to the public mental health system for non-urgent follow up, as he preferred private mental health care.*

Private referral to a bulk-billing psychiatrist in Brisbane was another potential alternative. I was not aware of any and at the time of my treatment there was no pressing clinical indication for a referral from me that could not have been arranged by his treating general practitioner. His mental state at the time was euthymic and he had fully recovered from his single episode of schizophrenia.

Referral back to his GP for ongoing monitoring and support was deemed the most appropriate option. I updated his GP Dr Grundy regarding the discharge and requested he recall Mr Cauchi to discuss future management options, including referral to a Brisbane psychiatrist if required. A minor consideration was also the fact that referrals from a psychiatrist are only valid for 3 months as opposed to referrals from [sic] a GP which are valid for 12 months under Medicare. ...";²⁷² and

- (b) *"I never planned to terminate Joel's psychiatric care but without a GP referral or a Medicare rebate a private psychiatrist cannot continue to treat their patient. When Medicare did not cover Joel's telehealth consult from Brisbane, and he did not want to or couldn't see me in person due to distance and practical reasons, I had to decide to transfer his care back to his family GP. At that time Joel was*

²⁷¹ Exhibit 1, Vol 19, Tab 785A, Supplementary statement of Dr Richard Grundy at [4]-[5].

²⁷² Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at p. 4

*not in an acute crisis and continued to remain apsychoptic and well without antipsychotic treatment for approximately 9 months”.*²⁷³

2.273 Counsel Assisting proposed to Dr Boros-Lavack (during her oral evidence) that there were three problems with the discharge/referral process, which are set out below along with Dr Boros-Lavack's responses:²⁷⁴

- (a) *First*, the referral was back to the GP in Toowoomba, without ensuring Mr Cauchi had a GP in Brisbane.

Dr Boros-Lavack agreed with this proposition.²⁷⁵

- (b) *Second*, there was no indication Mr Cauchi would need ongoing monitoring by a psychiatrist.

Dr Boros-Lavack did not accept this represented a mistake on her part. Dr Boros-Lavack gave evidence that:

- i. This was to be at the discretion of the GP. “Ongoing” and “care” were stated in the letter (referring to the GP, which was not an error).²⁷⁶
- ii. As to the meaning of “*if required*”, Dr Boros-Lavack said: “*because I would always have him back and that’s why if required*”.²⁷⁷
- iii. When asked what she meant by “*an alternative psychiatrist if required*”, Dr Boros-Lavack said “*[i]f required I can always be there...*”.²⁷⁸
- iv. When asked whether she considered that Mr Cauchi would require ongoing psychiatric care when he moved to Brisbane, Dr Boros-Lavack said: “*Mental health care, which can be, which can be, which can be delivered by, Dr Grundy is a very, very good mental health professional too. He, he looked after Baillie Henderson Hospital, so he, he knows about mental health. And that’s why I talked with him on the phone and said he would recall him, and he would discuss it with him. And that’s why I felt totally, totally relieved.*”²⁷⁹
- v. When it was put to Dr Boros-Lavack that Dr Grundy was not going to be the ongoing reviewing GP as he was based in Toowoomba rather than Brisbane, Dr Boros-Lavack said that: “*... it was interesting that he did not see me on 16 March, but three days later he saw Dr Barkla who is in Toowoomba*” and “*[s]o, he was in and out of Toowoomba. He just did not see me face to face, because he couldn’t commit himself to come monthly, but he saw Dr Barkla three days later*”.²⁸⁰

²⁷³ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [18].

²⁷⁴ Transcript, D11 (Boros-Lavack): T970.30-T972.50 (13 May 2025).

²⁷⁵ Transcript, D11 (Boros-Lavack): T970.30-33 (13 May 2025).

²⁷⁶ Transcript, D11 (Boros-Lavack): T970.35-T971.4 (13 May 2025).

²⁷⁷ Transcript, D11 (Boros-Lavack): T971.19-20 (13 May 2025).

²⁷⁸ Transcript, D11 (Boros-Lavack): T971.46-48 (13 May 2025).

²⁷⁹ Transcript, D11 (Boros-Lavack): T972.7-13 (13 May 2025).

²⁸⁰ Transcript, D11 (Boros-Lavack): T972.25-32 (13 May 2025).

However, there is no evidence in the medical records that Dr Barkla saw Mr Cauchi on or around 19 March 2020. Mr Cauchi's last appointment with Dr Barkla was one year earlier, on 5 March 2019 (as set out above).

- (c) *Third*, the letter to Dr Grundy does not refer to the recent concerns expressed by Mrs Cauchi (including that she thought Mr Cauchi might be hearing voices, she had found satanic notes, and she had noticed changes in his gait).

Dr Boros-Lavack did not agree that this was an error and said: "*No. Because the mother said not to say anything about it, and I was, I was totally, totally relieved that it wasn't a psychotic break and wasn't early warning signs of relapse.*"²⁸¹

- 2.274 It was submitted on behalf of the Good, Singleton and Young families (as an example of Dr Boros-Lavack purportedly not making appropriate concessions) that when asked to reflect on the adequacy of the discharge letter, Dr Boros-Lavack was adamant that she had made no error and gave evidence in a defensive manner.²⁸²

- 2.275 In the written submissions on behalf of Dr Boros-Lavack (dated 24 October 2025), it was submitted that since concluding her oral evidence (in May 2025), Dr Boros-Lavack had engaged in reflection and "*does concede there were deficiencies in the manner she discharged [Joel Cauchi] from her care*".²⁸³ This is addressed further below.

Whether there was a phone call between Dr Grundy and Dr Boros-Lavack

- 2.276 According to Dr Boros-Lavack, she also had a conversation(s) with Dr Grundy regarding Mr Cauchi's discharge, on an unspecified date(s). Dr Boros-Lavack states:

*I participated in a handover process by transferring Mr Cauchi's care back to his referring GP Dr Grundy via a letter dated 19 March 2020. I recall having other communications with Dr Grundy about the discharge. Albeit undocumented, I believe we discussed this unusual variance in his discharge pathway.*²⁸⁴

- 2.277 In oral evidence, Dr Grundy confirmed that he has no recollection of a phone call from Dr Boros-Lavack and does not believe that such a call took place.²⁸⁵ Dr Grundy also stated:

I do not recall any telephone discussion with Dr Boros-Lavack in relation to her letter dated 19 March 2020.

If I had a discussion with any specialist regarding patient care, my usual practice was to document this in the patient records.

If Dr Boros-Lavack has had a telephone discussion with me and recommended that I recall Joel or otherwise raised any risk of relapse, I would have done so. This is based

²⁸¹ Transcript, D11 (Boros-Lavack): T972.37-43 (13 May 2025).

²⁸² Written submissions on behalf of Good, Singleton and Young families at [4.60]-[4.62].

²⁸³ Written submissions on behalf of Dr Andrea Boros-Lavack at [2].

²⁸⁴ Exhibit 1, Vol 19, Tab 791, Supplementary statement of Dr Andrea Boros-Lavack at p. 4.

²⁸⁵ Transcript, D13 (Grundy): T1122.38-T1124.25 (15 May 2025).

on the expectation that Dr Boros-Lavack would have provided me with further information as part of any telephone discussion as to the need for recall.

*As I did not recall Joel and have not documented any discussion in Joel's patient records about any discussion with Dr Boros-Lavack, it is unlikely that any such discussion occurred.*²⁸⁶

- 2.278 Counsel Assisting submitted that: *"The Court could not be satisfied that there was any conversation between Dr Boros-Lavack and Dr Grundy, or of the nature of that conversation, in the absence of a contemporaneous note by either party that it occurred..."*²⁸⁷ and that I would not accept Dr Boros-Lavack's evidence that she called and spoke to Dr Grundy (for the reasons set out in the submissions on behalf of Dr Grundy and the Good, Singleton and Young families).²⁸⁸
- 2.279 Counsel Assisting submitted that in any event, it may not be necessary for me to make a finding as to this issue, as 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 last five months"*, as Dr Boros-Lavack herself had dismissed any likely concerns. Counsel Assisting submitted 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.²⁸⁹
- 2.280 The Good, Singleton and Young families made submissions with respect to Dr Boros-Lavack's manner in giving oral evidence on this topic and that Dr Boros-Lavack's evidence regarding the phone call to Dr Grundy was not credible, was inconsistent, and should not be accepted. These families invited a finding that Dr Boros-Lavack's evidence regarding any telephone call with Dr Grundy was a recent invention and knowingly false.
- 2.281 It was submitted on behalf of Dr Boros-Lavack that I would not be satisfied that Dr Boros-Lavack's evidence was knowingly false, that her recollection was genuinely held, and that it is unsafe to rely on Dr Grundy's recollection (as he also initially did not recall receiving the discharge letter).
- 2.282 It was submitted on behalf of Dr Grundy that portions of Counsel Assisting's and the families' submissions are adopted regarding this issue, and that:

*Even if a finding were made that a telephone call was made, Dr Boros-Lavack's sworn oral evidence is entirely opaque as to what information, if any, regarding Mr Cauchi's-mental state, current diagnosis, management and treatment plan, risks of relapse, signs of relapse, review period, or psychiatric referral urgency was given to Dr Grundy. The only detail Dr Boros Lavack is clear on, is that she informed Dr Grundy that she could no longer treat Mr Cauchi as a result of his ineligibility for Skype consultations.*²⁹⁰

²⁸⁶ Exhibit 1, Vol 19, Tab 785A, Supplementary statement of Dr Richard Grundy at [10]-[13].

²⁸⁷ Written submissions of Counsel Assisting at [396](a).

²⁸⁸ Transcript, Closing Submissions D1: T1915.50-T1916.2 (25 November 2025).

²⁸⁹ Transcript, Closing Submissions D1: T1915.50-T1916.7 (25 November 2025).

²⁹⁰ Written submissions on behalf of Dr Grundy, Dr Ruge and Dr Parkar at [13].

- 2.283 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.

Further events in relation to Mr Cauchi's discharge

- 2.284 Once Mr Cauchi moved to Brisbane, he would have been living in the Brisbane South or Brisbane North PHN area.²⁹¹ It is unclear from the available evidence whether an MHNCP or equivalent was available in those Brisbane PHN areas as at March 2020 (and subsequently).

- 2.285 On 1 April 2020, RN Brooks returned from leave and began working from home due to the COVID-19 pandemic. RN Brooks states: *"Upon my return, I became aware that Joel had moved to Brisbane. I was informed that given Joel now resided outside of the MHNCP Toowoomba's boundary for service he was no longer eligible for our services"*.²⁹²

- 2.286 Further, RN Brooks states:

... When a person left the area, there was a precedent where I had some more phone calls with them to support and facilitate their transition to a new location prior to ending the MHNCP and closing the referral for the Toowoomba MHNC program. This possibly could have applied to Joel too, especially if I had been at work at the time of his management and care from [Dr Boros-Lavack] was ended.

I did not find out that Joel had been discharged until after I returned from leave. To the best of my knowledge there were no alternatives to Joel being discharged as he no longer fit the criteria for the provision of services due to his relocation outside of the catchment.

...

*I was not involved in the handover process of Joel's care to any other health provider after he was discharged from the service. I understand that this would have been completed by Joel's psychiatrist, Dr Boros-Lavack.*²⁹³

- 2.287 Mr Cauchi's scheduled appointment at the Mi-Mind Centre on 2 April 2020 with RN Brooks was cancelled by Mi-Mind Centre (seemingly by Ms Hartin). The note states:

²⁹¹ Exhibit 1, Vol 50, Tab 1619A, Statement of Lucille Chalmers (Chief Executive Officer, Darling Downs and West Moreton Primary Health Network) at [21].

²⁹² Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Books at [50].

²⁹³ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Books at [19]-[20], [50], [79]-[89].

*"Not able to Skype as now living in Brisbane DH".*²⁹⁴ On 9 April 2020, RN Brooks closed Mr Cauchi's referral to the MHNCP.²⁹⁵

- 2.288 The St Andrews Medical Centre records include a seemingly unsigned letter dated 11 May 2020 addressed to Mr Cauchi, from the "Recall Administrator" at St Andrews Medical Centre. The letter requested that Mr Cauchi make an appointment at his earliest convenience with his doctor for follow-up blood testing. This letter was addressed to an address in Toowoomba (rather than Brisbane), which was not the Cauchi family home.²⁹⁶ The evidence suggests Mr Cauchi did not attend St Andrews Medical Centre after this time.²⁹⁷

Comments of Mi-Mind Centre staff regarding care of Mr Cauchi

- 2.289 Dr Boros-Lavack states as follows in relation to her overall care and treatment of Mr Cauchi:²⁹⁸

- (a) With respect to the period of time that Dr Boros-Lavack was Mr Cauchi's treating psychiatrist: *"During this period Joel was assessed as clinically stable and displayed no indications of being psychotic even though he had a diagnosed brief intercurrent period of early warning signs of relapse in the context of his fear of possible STD in November 2019, which went away with early intervention without restarting the recommended antipsychotic medication. He never demonstrated that he was a risk to himself or others. There were no signs of an episode of psychosis, violent ideation, no expression of interest in weapons, and no behaviours that would have warranted compulsory intervention. He was managing his illness with the support of regular medical supervision, in collaboration with medication until June 2019, almost for 7 years and with the support of his family, with whom he was residing until he moved out from home for the first time to live independently in his Toowoomba unit from Oct 2018";*
- (b) *"For 8 years Joel presented as stable and was actively engaged in his ensuring his mental stability. As a voluntary patient during the time, he was under my medical supervision, he was apsychotic and presented as stable.*

I have combed through all my case notes, and I am clear that there were no early indications of psychotic relapse or any tendencies towards violence when he was under my medical supervision"; and

- (c) *"Joel had shown significant clinical improvement by 2019 and sustained remission of his symptoms. Over the years, we had gradually de-prescribed his Clozapine dose, and he remained stable without any relapse of his positive*

²⁹⁴ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 19.

²⁹⁵ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [51]. See also Exhibit 1, Vol 19, Tab 792F, Supplementary statement of RN Andrea Brooks at [7], [9], [40].

²⁹⁶ Exhibit 1, Vol 19, Tab 788A, Additional St Andrews Medical Centre medical records at p. 49.

²⁹⁷ See Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records; Exhibit 1, Vol 19, Tab 788A, Additional St Andrews Medical Centre medical records.

²⁹⁸ Exhibit 1, Vol 19, Tab 791A, Second supplementary statement of Dr Andrea Boros-Lavack at [5], [7], [13].

symptoms. His negative and cognitive symptoms also fully remitted. Given his continuous improvement and the absence of psychotic symptoms, we collaboratively decided to discontinue both Clozapine and then Abilify. This decision was made with careful consideration of the benefits versus the harms of continuing treatment, and Joel remained stable off medications for over nine months before his care had to be transferred back to his referring family GP ...”.

- 2.290 Dr Boros-Lavack described Mr Cauchi as follows: *“My impression of Joel was a nice and non-violent young man with lived experience of schizophrenia who liked coming to Mi-Mind Centre for his regular reviews. He had a good relationship with not only myself and his Credentialed Mental Health Nurses, but the receptionists and other staff and psychiatrists in the Clinic”.*²⁹⁹
- 2.291 RN Schwarz states that over the nine years that she regularly observed Mr Cauchi, his mental health remained substantively stable, however his chronic condition had a significant impact on his overall functioning and development in some domains (for instance, he had poor social skills and needed guidance with everyday tasks). RN Schwarz states Mr Cauchi was generally *“very polite and courteous”*. His energy, mood, motivation levels and quality of life appeared to gradually improve.³⁰⁰
- 2.292 RN Brooks’ general observations of Mr Cauchi include the following:³⁰¹
- (a) Mr Cauchi was generally *“calm without agitation”* and *“always polite, respectful, cooperative with conversation and responses”*. He generally had a positive mood and optimism, was *“quietly spoken”*, had a slowness of speech and often paused before answering questions and was considered in his responses. RN Brooks *“never heard him swear”*. Mr Cauchi spoke of his church, but did not express themes of a religious nature or religious ideology or beliefs. RN Brooks did not observe any occasion on which Mr Cauchi presented as depressed or with a flat mood.
 - (b) Mr Cauchi was punctual and *“positively engaged for his appointments, he actively participated in conversation and my observation was that he enjoyed discussions and initiated topics for discussion”*.
 - (c) Mr Cauchi was willing to attend appointments to gain support and have frank conversations regarding his treatment and ongoing management. He would *“pro-actively seek appointments between those scheduled when he had a need to ask for something”*.
 - (d) Mr Cauchi generally had a good history of medication compliance.

²⁹⁹ Exhibit 1, Vol 19, Tab 790, Statement of Dr Andrea Boros-Lavack at p. 21.

³⁰⁰ Exhibit 1, Vol 19, Tab 792C, Statement of RN Clare Schwarz at [23]-[34].

³⁰¹ Exhibit 1, Vol 19, Tab 792B, Statement of RN Andrea Brooks at [35]-[43].

- (e) Mr Cauchi could make reasonable judgements as to what he was doing and how he was living and managed his studies well. However, he required support to regain skills for daily living activities.
- (f) Mr Cauchi had fair insight and judgement into the illness and possibility of relapse. He did have difficulty recalling features of the illness when it began, including when asked about relapse symptoms.
- (g) RN Brooks observed Mr Cauchi to have facial tics or turns of the head on occasion, however he denied symptoms such as hearing voices and RN Brooks did not detect delusional thoughts or systems. He sometimes would struggle to maintain the thread of a conversation.
- (h) Mr Cauchi asked for information regarding how to talk to women as he wanted a relationship.

Standard of care provided by nurses at Mi-Mind Centre

2.293 Counsel Assisting submitted as follows with respect to Mr Cauchi's care from RN Brooks and RN Schwarz at Mi-Mind Centre:

- (a) *"The Court would have been impressed by the evidence of the two nurses who assisted Mr Cauchi over a lengthy period of time at the Mi-Mind Centre – Ms Clare Schwarz and Ms Andrea Brooks";*³⁰² and
- (b) RN Brooks and RN Schwarz *"both impressed as highly qualified, professional and compassionate"* and came across as *"caring and competent"*.³⁰³

2.294 Counsel for RN Brooks and RN Schwarz submitted:

- (a) *"Counsel Assisting is not critical of either RN Brooks nor RN Schwarz, as experienced mental health clinicians, in relation to the standard of care and concern they showed Mr Cauchi, nor in relation to their conduct as witnesses at the hearing of the inquest."*

*RN Brooks and RN Schwarz respectfully acknowledge the submission at [390] that '... for a substantial period in which Mr Cauchi was treated at the Mi-Mind Centre, he received a high standard of care, and was seen regularly by qualified practitioners'. RN Brooks and RN Schwarz respectfully acknowledge the submissions made on behalf of the families";*³⁰⁴ and

- (b) *"... we endorse the submissions made by counsel assisting in regard to the appropriateness of the care they provided to Joel Cauchi. Counsel assisting*

³⁰² Written submissions of Counsel Assisting at [526].

³⁰³ Written submissions of Counsel Assisting at [529]; Transcript, Closing Submissions D2: T1900.6-8 (25 November 2025).

³⁰⁴ Written submissions on behalf of RN Clare Schwarz and RN Andrea Brooks at [5]-[6].

observed that both nurses impressed as highly qualified, professional and compassionate.

*Further, that both were shocked by the tragic events of 13 April, and both had noted that the actions were wholly inconsistent with the gentle and polite patient that Mr Cauchi had been”.*³⁰⁵

Findings

- 2.295 Mr Cauchi received a good mental health service from the nurses at Mi-Mind Centre.
- 2.296 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.
- 2.297 RN Brooks and RN Schwarz were consistent, available, open, and flexible when providing mental health care to Mr Cauchi.

Standard of care provided by Dr Boros-Lavack

Expert evidence

- 2.298 In relation to the concerns raised by Mrs Cauchi from October 2019 to early 2020, and whether Mr Cauchi was experiencing early warning signs of relapse in that period, the evidence of the expert psychiatrists included the following:
- (a) Professor Nielssen opined in his oral evidence, in relation to the period of time when Mr Cauchi was reluctant to recommence medication (whilst still under Dr Boros-Lavack's care), that as a psychiatrist he would definitely have had a high index of suspicion that Mr Cauchi may have been masking symptoms at that stage, and *“it's clear that he's relapsing but how urgent it is to treat it isn't quite as, quite as clear. And then suddenly we've got COVID and he's moved to Brisbane”*.³⁰⁶
 - (b) Professor Harris gave evidence that:
 - i. *“... I certainly agreed that that is there a series of symptoms very suggestive of a relapse of his psychotic illness”*;³⁰⁷
 - ii. *“In summary the concerns expressed by Mrs Cauchi about the possible relapse of her son were treated seriously by Dr Boros-Lavack and her practice. He was seen numerous times over this period and a script provided for him to obtain medication if he thought he was experiencing early warning signs of psychosis. It is clear from the notes of Dr Boros-Lavack that she did not think that Mr Cauchi was psychotic when she saw him. It may be that she was overly optimistic that he would restart*

³⁰⁵ Transcript, Closing Submissions D2: T1976.27-35 (28 November 2025).

³⁰⁶ Transcript, D16 (Nielssen): T1439.46-38 (22 May 2025).

³⁰⁷ Transcript, D16 (Harris): T1450.9-11 (22 May 2025).

*medication if he became unwell again, however she had a long relationship with Mr Cauchi who had always been cooperative and adherent to treatment”;*³⁰⁸ and

- iii. As at 28 November 2019, Mr Cauchi could have been referred to a public mental health team.³⁰⁹

(c) Professor Heffernan opined:

- i. *“The cessation of clozapine was associated with a relapse of his illness. From the information available it is likely that the relapse of illness, including psychotic symptoms, disorganisation and poor decision making commenced in 2019 and continued and worsened until the time of his death”;*³¹⁰
- ii. Subtle things, some of which were more concerning than others, when collectively put together are flags of a probable psychotic relapse (in relation to insomnia, Mrs Cauchi suspecting symptoms, changes in behaviour, satanic control, and pre-occupation with religious themes);³¹¹ and
- iii. As at 28 November 2019, *“a more assertive approach in terms of encouraging restarting medication”* needed to be considered.³¹² Mr Cauchi could also have been referred to a public mental health team for review or assistance.³¹³

(d) Professor Nordentoft opined that:

- i. Mr Cauchi’s *“first warning signs of relapse started after just a few months without medication”* (that is, after Abilify was ceased);³¹⁴
- ii. *“I think that the mother’s concerns are being voiced very - they’re very clear, both in letters and in the telephone contacts. And, and I think it is - I, I think it’s not taken seriously enough in the autumn of 2019 where she several times reports being worried, and she reports that she’s seen him - that his place is in a very messy state, and there are notes indicating that he might hear voices. And I think she’s the best observer, and, and I think Joel might at that point be able - in short, or maybe also a little bit longer conversation - been able - be able to mask the real state of, of his mind.*

³⁰⁸ Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [4.9].

³⁰⁹ Transcript, D16 (Harris): T1441.9-14 (22 May 2025).

³¹⁰ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [2.45].

³¹¹ Transcript, D16 (Heffernan): T1434.16-23 (22 May 2025).

³¹² Transcript, D16 (Heffernan): T1439.23-31 (22 May 2025).

³¹³ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [7.2.1].

³¹⁴ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [86].

*So that, that Michele's report might actually be the most accurate reflection of how he was at that time”;*³¹⁵

- iii. *“Yes, I agree that there are several red flags and I think the most important ones are the concerns raised by his mother, who is the one who know most about his, his condition. ...”;*³¹⁶
- iv. Mrs Cauchi's report from 14 February 2020 (as for the report in November 2019) underlines that Mr Cauchi was deteriorating and that it would have been appropriate to try to persuade him to take antipsychotic medication again;³¹⁷ and
- v. As at March 2020, *“there were clear indications of risk of relapse (sleep difficulties, mothers concern, inappropriate text messages to the psychiatrist)”*.³¹⁸

(e) Professor Large:

- i. As noted above, in oral evidence when asked about the notes found with Satanic themes, opined that *“they were concerning things that required some further investigation”*, although he indicated that when the nurse examined Mr Cauchi on 20 November 2019 it was *“a bit of an intermediate result”* and the nurse could not elicit hallucinations or delusions;³¹⁹ and
- ii. Opined that *“While there was some evidence that he later had a decline in his mental state after ceasing all antipsychotics, it was never fully clear that he had positive symptoms ...”*³²⁰ and that whilst it *“certainly looks like a relapse”*, Professor Large would not have been comfortable to introduce compulsory treatment for Mr Cauchi as at 28 November 2019.³²¹

2.299 Professors Heffernan, Nielssen, Large and Harris agreed that Mr Cauchi did not reach the legislative threshold for involuntary treatment whilst receiving care at the Mi-Mind Centre. They all agreed that accordingly, Mr Cauchi's decision as to whether to take antipsychotic medication had to be accepted.³²²

2.300 However, Professor Nielssen noted *“whether or not greater attempts could have been made to persuade him based on long, long association is another matter”*;³²³ Professor Harris commented *“it would be reasonable to have demonstrated greater efforts to try and institute subsequent aripiprazole or brexpiprazole when [Dr Boros-Lavack] thought*

³¹⁵ Transcript, D16 (Nordentoft): T1421.9-18 (22 May 2025).

³¹⁶ Transcript, D16 (Nordentoft): T1434.34-45 (22 May 2025).

³¹⁷ Transcript, D16 (Nordentoft): T1445.12-17 (22 May 2025).

³¹⁸ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [102].

³¹⁹ Transcript, D16 (Large): T1440.44-50 (22 May 2025).

³²⁰ Exhibit 1, Expert Volume, Tab 12, Expert Report of Professor Matthew Large at [237].

³²¹ Transcript, D16 (Large): T1440.44-50 (22 May 2025).

³²² Transcript, D16 (Heffernan, Nielssen, Large, Harris): T1495.20-T1496.3 (22 May 2025).

³²³ Transcript, D16 (Nielssen): T1495.10-13 (22 May 2025).

*that ... that may have been warranted...";*³²⁴ and Professor Nordentoft opined that there was a missed opportunity, when the nurse had a discussion with Mr Cauchi and he agreed to re-commence anti-psychotic medication, as it *"should have been reintroduced at that time"*.³²⁵

2.301 In addition, Professor Nielssen opined, regarding Mr Cauchi's care from Dr Boros-Lavack and Mi-Mind Centre from 2012 to 2020, that: *"I mean it was exemplary, it was above and beyond really up until the end. It was just the, the handover was care was [sic], there were some shortcomings there"*.³²⁶ Professor Harris and Professor Heffernan agreed that the one area for improvement of care was the discharge handover in 2020.³²⁷

2.302 Professor Large gave evidence that the Mi-Mind Centre care of Mr Cauchi was *"well within the acceptable standard of care"*³²⁸ and Dr Boros-Lavack's management of Mr Cauchi was generally appropriate.³²⁹

2.303 In terms of Mr Cauchi's discharge from Mi-Mind Centre in 2020 (and Dr Boros-Lavack's letter to Dr Grundy dated 19 March 2020), the expert psychiatrists opined as follows:

(a) Professor Nielssen:

- i. *"Given the long therapeutic relationship, and the risks associated with ceasing antipsychotic medication completely, it would have been appropriate for Dr Boros-Lavack to liaise with Mr Cauchi's mother regarding his condition and care, and to perhaps have arranged a further fully rebated telehealth consultation in April 2020, when it seems he was looking to be referred to a psychiatrist in Brisbane";*³³⁰ and
- ii. The letter from Dr Boros-Lavack to Dr Grundy was insufficient and incomplete in terms of the recent events.³³¹

(b) Professor Harris:

- i. *"Dr Boros-Lavack delegated responsibility for arranging continued care back to his treating general practitioner, Dr Grundy and also to Mr Cauchi, himself. Dr Boros-Lavack certainly regarded continued care for Mr Cauchi as being necessary given her initial plan to continue care via Skype. It was also clinically indicated given the recent concerns about his possible relapse, the change in his behaviour with the evidence of his sexually exploring which was very different to his usual behaviour in Toowoomba and finally the stress likely to be experienced by Mr Cauchi as he navigated*

³²⁴ Transcript, D16 (Harris): T1495.29-34 (22 May 2025).

³²⁵ Transcript, D16 (Harris): T1495.29-34 (22 May 2025).

³²⁶ Transcript, D16 (Nielssen): T1497.38-40 (22 May 2025).

³²⁷ Transcript, D16 (Harris): T1497.34-T1498.1 (22 May 2025); Transcript, D16 (Heffernan): T1497.44-47 (22 May 2025).

³²⁸ Transcript, D16 (Large): T1498.5 (22 May 2025).

³²⁹ Exhibit 1, Expert Volume, Tab 12, Expert Report of Professor Matthew Large at [222]-[225].

³³⁰ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [136].

³³¹ Transcript, D16 (Nielssen): T1450.32-35 (22 May 2025).

living alone. Given these concerns it would have been reasonable for Dr Boros-Lavack to be more assertive in arranging for ongoing care for Mr Cauchi in Brisbane either by suggesting a private psychiatrist in the Brisbane area for Mr Cauchi to contact or for Dr Grundy to refer to, or by referral to the local community mental health team when Mr Cauchi was able to give an address. This would have better ensured a smooth handover of care for Mr Cauchi to a new clinical team”,³³² and

- ii. It would have been preferable for Dr Boros-Lavack's letter to include more information, including diagnosis/es, details of ongoing treatment, and the concerns about a possible relapse. The letter was brief and did not include a lot of information that would have been reasonable to include in it.³³³

(c) Professor Heffernan:

- i. *“I think [Mr Cauchi] should have been referred to a psychiatrist in Brisbane for ongoing assessment and management. The circumstances would have been challenging as outlined above, but his long history of schizophrenia, treatment with clozapine, and evidence of a potential relapse indicated the need for comprehensive psychiatric assessment and ongoing care. There were grounds for a referral to the public mental health system if other adequate care arrangements could not be coordinated”,³³⁴ and*
- ii. Dr Boros-Lavack's discharge letter should have included Mr Cauchi's symptoms and mental state; Mrs Cauchi's concerns about possible relapse (which Dr Boros-Lavack could have noted she did not share); and Dr Boros-Lavack's intention with respect to antipsychotic medication.³³⁵

(d) Professor Nordentoft:

- i. Mr Cauchi required ongoing monitoring by a psychiatrist (at least monthly, although Professor Nordentoft herself would have preferred closer monitoring);³³⁶ and
- ii. It would have been appropriate for the letter from Dr Boros-Lavack to include the concerns about the risk of relapse reported by Mrs Cauchi.³³⁷

(e) Professor Large:

- i. It was quite appropriate to refer back to primary care when it was no longer possible for Dr Boros-Lavack to continue Mr Cauchi's treatment after he

³³² Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [4.11].

³³³ Transcript, D16 (Harris): T1453.37-44 (22 May 2025).

³³⁴ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [4.11].

³³⁵ Transcript, D16 (Heffernan): T1451.31-37, T1453.46-T1454.7, T1451.4-24 (22 May 2025).

³³⁶ Transcript, D16 (Nordentoft): T1447.27-T1447-31 (22 May 2025).

³³⁷ Transcript, D16 (Nordentoft): T1447.7-18 (22 May 2025).

moved to Brisbane.³³⁸ It is also very difficult for a private psychiatrist to refer to another private psychiatrist;³³⁹

- ii. Mr Cauchi needed to be reviewed monthly by a psychiatrist and it would have been much better for Dr Boros-Lavack to have advised someone upon discharge that Mr Cauchi needed regular review;³⁴⁰ and
- iii. The concerns about possible relapse should have been raised with Dr Grundy.³⁴¹

2.304 The expert GPs opined as follows in relation to the discharge process:

(a) Dr Wilson:

- i. *"Mr Cauchi's mental health had been stable for some years and it appears he had capacity to make his own treatment decisions. Taking control of his own treatment decision was an important process for him to learn to manage; however, no health practitioner held the locus of care for Mr Cauchi. While the doctors he saw undertook assessments based on his presentation and requests for management of acute issues, no one understood his history in detail.*

...

The lack of access to detailed history was an issue for practitioners seeing Mr Cauchi after 2019...a single record that allows all involved in care, whether public, private or non-government organisations across all states and territories that allows access to medical records would have assisted in understanding the trajectory of care and Mr Cauchi's history, presentation and well-being";³⁴² and

- ii. In oral evidence:

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

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

³³⁸ Exhibit 1, Expert Vol, Tab 12, Expert Report of Professor Matthew Large at [226].

³³⁹ Transcript, D16 (Large): T1459.17-T1460.10 (22 May 2025).

³⁴⁰ Transcript, D16 (Large): T1475.40-T1476.11 (22 May 2025).

³⁴¹ Transcript, D16 (Large): T1452.1-27 (22 May 2025).

³⁴² Exhibit 1, Expert Volume, Tab 4, Expert Report of Dr Hester Wilson at pp. 22-23, lines 538-546, 563-567.

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

WITNESS WILSON: Yeah, yes.

HER HONOUR: It's important, the wording.

WITNESS WILSON: Yeah, yeah. So, "Please recall Joel to discuss his options and, and referral to an alternative psychiatrist if required." Is the recall required or is the referral required? It, it's, it's not - it is a little bit open to interpretation. I - it does seem very precipitous, you know. "Okay, so he can't see me, so he's going to come and see you," and yet the GP is also in Toowoomba, how is the patient going to get back and see the GP? And, and just, yeah, I - it does say "recall". Ideally, you know, as a GP, you would have tried to get in contact with Joel to follow up, but I can understand why it might not have happened, given the, given the, that it's not entirely clear.

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

WITNESS WILSON: And, and this is on the background of Dr Grundy believing that Joel had been doing very well, you know, and been, been very well post stopping his medication, so it, it, you know, potentially it's, "Well, he's doing well. If he wants to come back, he can, he can see me and I'll have a chat to him and refer him if required," could be an interpretation."³⁴³

(b) Dr Kruys:³⁴⁴

- i. *"Although discharge back to the referring GP is formally an appropriate action, the outcome of appropriate follow-up care was doubtful in this case, as Mr Cauchi had already left town";*
- ii. *"From a continuity of care perspective there appears to be a missed opportunity by Dr Boros-Lavack's office to organise follow-up care by a colleague psychiatrist in the Brisbane area. A specialist-to-specialist referral is valid for a period of 3 months as per Medicare requirements. If a referral to another psychiatrist was not required, recommendations for GP follow-up would have been helpful";*
- iii. *The discharge letter from Dr Boros-Lavack to Dr Grundy did not contain recommendations for ongoing psychiatrist reviews or multidisciplinary/primary care following discharge;*
- iv. *There appears to be a missed opportunity for the GP team "to assist Mr Cauchi with follow-up care by a GP and/or psychiatrist in the Brisbane area. It is acknowledged that this step is not routinely part of the care when not requested by the patient but could have been considered given Mr*

³⁴³ Transcript, D17 (Wilson/Kruys): T1593.31-T1594.13 (23 May 2025).

³⁴⁴ Exhibit 1, Expert Volume, Tab 6, Expert Report of Dr Edwin Kruys at [24](c)-[24](g).

Cauchi's mental health history and the risk associated with no follow up care"; and

- (c) In oral evidence, Dr Kruys and Dr Wilson also gave the following expert evidence (as well as agreeing that the information as to the recent events involving Mr Cauchi should have been provided to Dr Grundy):

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

WITNESS KRUYIS: So, so I think that in general, it is good practice to consider recommendations requested by specialist colleagues. I, I think as the GP, you have the overall responsibility of the care, even though you give part of that responsibility to a specialist when you refer. You remain as the GP having that overall responsibility at the end of the episode of care with the specialist. Mr Cauchi's a vulnerable patient, there's a risk of relapse, associated health risk, a chronic condition, so there is an expectation I think to recall the patient at this point. However, there are few considerations and that is indeed, as already has been said, there's minimal, has been minimal involvement in the mental health care and suddenly the GP is being asked to make decisions about that care, whereas he has not been involved in any decisions over the past few years. He was also not fully informed. We know that there was a lot more happening than is visible in this letter. And I would argue although this is a, this is a discharge letter, it is not a clinical handover letter, and as such, Dr Grundy would not have been in a position to make a fully informed decision.

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

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

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

WITNESS KRUYIS: Yes.

WITNESS WILSON: Yes, it would, but I, I guess I'm thinking about all those letters that came to the GP that was saying, "Doing really well. Stopped his medication.

Been well for a year." It's, it, it, it creates a more complex picture, you know. If you just take that bit of information, you know, "He is at risk of relapse and will need long term medication," out, but what we've got is the whole kind of trajectory of how well he was doing that was expressed in the letters.

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

WITNESS KRUYIS: Yes, yeah.

WITNESS WILSON: Mm.

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

HER HONOUR: No, of course not.

WITNESS KRUYIS: Yeah.

DWYER: Dr Grundy's evidence ...

...

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

WITNESS WILSON: Yeah, I think once again it goes, goes back to the, to the, to the information that Dr Grundy had in his experience of Joel, and, yes, he had been seeing Joel for, you know, many years. However, he'd seen him for intermittent, you know, occasional general health stuff, and had done a few investigations, as requested by the psychiatrist, but really hadn't been involved in, in the management of his, his chronic mental health. I mean, it's, it's a missed opportunity once again, and, you know, I'd like to think that if I got that letter that I would do something. But it's, it's just not clear, you know, and that's, I guess that's the thing; would be can we, can we shift this so that there's communications and that safe transfer of care, or handover of care, it, it has really clear roles and responsibilities, you know, that, that really help us to go, "Okay, so it's really clear I need to do this", you know, "so, I will, I will get my receptionist to get, give him a call and book an appointment."

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

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

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

WITNESS WILSON: Yep.

...

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

WITNESS WILSON: Yep, absolutely.

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

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

WITNESS WILSON: The options are.

*WITNESS KRUYIS: And if required, and - well, "Well, does he need a psychiatrist referral or not?", I might just pick up the phone or send a quick letter to her, "What is it exactly that you want to do?" That's easier said than done, if you have a lot of patients and you're running an hour late, and there's angry patients in the waiting room."*³⁴⁵

Submissions

Submissions of Counsel Assisting

2.305 In summary, Counsel Assisting submitted as follows with respect to Dr Boros-Lavack's care of Mr Cauchi:

- (a) For the majority of the time that Mr Cauchi was treated at the Mi-Mind Centre, he received a very good standard of care, and a number of aspects of the care provided by Dr Boros-Lavack via Mi-Mind Centre were extremely positive.

This included that there was a good set-up at Mi-Mind Centre with quality care by a multi-disciplinary team; he saw skilled mental health nurses; Mr Cauchi saw nursing staff and Dr Boros-Lavack very regularly from 2012 to 2020; Mrs Cauchi was able to easily get in contact with clinic staff; and Dr Boros-Lavack took the careful and appropriate step of obtaining a second opinion in May 2015.

- (b) Dr Boros-Lavack considered that after ceasing psychotropic medication, Mr Cauchi was (or possibly was) experiencing early warning signs of relapse, although he was not psychotic. She maintained that Mr Cauchi did not have a psychotic relapse in the time she looked after him.

³⁴⁵ Transcript, D17 (Wilson/Kruys): T1594.15-T1597.47 (23 May 2025).

- (c) However, Dr Boros-Lavack failed to respond appropriately to the early warning signs reported by Mrs Cauchi in late 2019 and early 2020, which were also exhibited in correspondence from Mr Cauchi to Mi-Mind Centre. The experts accepted unanimously that those were early warning signs.

Dr Boros-Lavack's failure to recognise early warning signs of relapse, and more proactively agitate for Mr Cauchi to resume medication, are "*major failings*". He should have been more thoroughly reviewed and more effort should have been made to persuade him to take medication.

- (d) The process of Mr Cauchi's discharge from Dr Boros-Lavack to Dr Grundy was inadequate and wholly unsatisfactory. The three main problems with the referral process were:
 - i. The referral was back to the GP in Toowoomba, without ensuring Mr Cauchi had a GP in Brisbane;
 - ii. There was no indication in the referral letter that Mr Cauchi would need ongoing monitoring by a psychiatrist. At best, the letter is worded ambiguously; and
 - iii. The letter does not refer to the recent concerns expressed by Mrs Cauchi (including that she thought Mr Cauchi might be hearing voices, she had found satanic notes, and she had noticed changes in his gait).
- (e) The inadequate handover had significant consequences for Mr Cauchi's ongoing care when Mr Cauchi had interactions with other specialists after Mi-Mind Centre.
- (f) Mr Cauchi only saw two psychiatrists after Mi-Mind Centre (on one occasion each) and both occurred as he wanted a Statement of Eligibility.
- (g) Counsel Assisting submitted that I should make specific key findings that are critical of Dr Boros-Lavack, relating to the following: Dr Boros-Lavack's evidence regarding "first episode psychosis" was disingenuous and raises serious doubts as to her credibility and professional competency; the decision to cease clozapine was, in hindsight, a tragic error; Dr Boros-Lavack did not provide adequate guidance to Mr Cauchi's family or GP as to the risk of relapse; Dr Boros-Lavack did not adequately monitor Mr Cauchi for early warning signs of relapse and did not adequately respond when Mrs Cauchi reported early warning signs on a number of occasions from October 2018 to February 2020 (despite Mrs Cauchi being best placed to report early warning signs of relapse) or when Mr Cauchi expressed concern about his prolific use of pornography towards the end of his treatment; Dr Boros-Lavack should have had a high index of suspicion for signs of relapse and her failure to do so is a major reason that Mr Cauchi came to be lost to mental health follow-up; in accordance with Professor Nordentoft's opinion, Mr Cauchi had some signs of emerging relapse in the months after ceasing Abilify and Dr Boros-Lavack displayed very little

assertiveness regarding him resuming medication; the discharge process back to Dr Grundy was flawed (detailed above); and the notes of Dr Boros-Lavack do not reflect a high standard of care and did not allow another practitioner to understand her decision-making.

- (h) In her evidence, Dr Boros-Lavack presented as combative, confrontational and with an exceptional level of belligerence; failed to accept responsibility for deficiencies; and failed to demonstrate insight or true understanding about where there were missed opportunities to provide better care. Dr Boros-Lavack had every opportunity to make appropriate concessions whilst giving evidence and did not. She was unwilling to reflect and learn at that time.
- (i) The concession made on behalf of Dr Boros-Lavack (relating to the handover process) is welcome, albeit belated. However, I may not be satisfied that it is reflective of any genuine insight on behalf of Dr Boros-Lavack (as whilst that may be the case, it cannot be tested). The concession was contained in the submissions on behalf of Dr Boros-Lavack, although it is regrettable she did not make a written statement addressing her reflections.

Further, in her oral evidence on 13 May 2025, Dr Boros-Lavack gave the following answer:

“Q. On reflection, do you think that there is more that you could've done by way of handover to ensure that Joel was seen after his move to Brisbane?”

A. No. Because I handed over to the original GP who knew the family and Joel well, and I hand it over and I felt that a private psychiatrist I, I correctly done the exit, which is a private psychiatric issue, and I can't change the system.”³⁴⁶

- (j) Submissions on behalf of Dr Boros-Lavack cherry-picked aspects of her evidence. Her evidence was wildly inconsistent at times and attempting to make sense of her oral evidence is extremely difficult.
- (k) Dr Boros-Lavack's evidence as to whether or not she did recognise that Mr Cauchi was experiencing early warning signs that indicated relapse is “*just simply unclear*”.³⁴⁷

Counsel Assisting submitted that the evidence does suggest that initially Dr Boros-Lavack thought there were early warning signs but she convinced herself within about one week that they were not and that it was a result of his concerns about sexual matters. Counsel Assisting submitted that was an error, however that Dr Boros-Lavack did not want to accept that there were early warning signs even with the benefit of reflection.

³⁴⁶ Transcript, D11 (Boros-Lavack): T980.15-20 (13 May 2025).

³⁴⁷ Transcript, Closing Submissions D1: T1906.49-T1907.5 (25 November 2025).

- 2.306 Counsel Assisting did *not* submit that Mr Cauchi could or should have received involuntary care in February 2020; however, they submitted that the concerns raised by Mrs Cauchi should have been given greater weight, “*they should have rung alarm bells more, they called for deeper investigation*”, and more effort could have been made to encourage Mr Cauchi to resume his medication.³⁴⁸

Submissions on behalf of the Good, Singleton and Young families

- 2.307 The submissions on behalf of the Good, Singleton and Young families agreed that aspects of the Mi-Mind Centre care of Mr Cauchi were of a high standard (as submitted by Counsel Assisting).
- 2.308 However, the families submitted that Dr Boros-Lavack ignored, missed or underestimated early warning signs of relapse and (as submitted by Counsel Assisting) discharged Mr Cauchi in a way that was wholly unsatisfactory.
- 2.309 The families relied upon Counsel Assisting’s submissions regarding inadequacies with the discharge letter. In terms of the concessions made on behalf of Dr Boros-Lavack regarding Mr Cauchi’s discharge, the families submitted that was belated, although welcome, and it did not undo the lack of judgement and insight she demonstrated throughout the Inquest (in her evidence and submissions made on her behalf). They further submitted that the discharge process was far worse than subpar.
- 2.310 The families submitted that from the point of discharge from Mi-Mind Centre, Mr Cauchi fell through the cracks of the mental health care system. They submitted that when Dr Boros-Lavack took over Mr Cauchi’s care he was a high-functioning individual leading a productive and meaningful life, whereas after Dr Boros-Lavack ceased all medication, Mr Cauchi declined into a perilous state where he was estranged from his family, destitute and homeless. They submitted this was itself a tragic outcome and in stark contrast to his relative stability before Dr Boros-Lavack’s intervention.
- 2.311 The families submitted that Dr Boros-Lavack in evidence refused to admit any error, even with the benefit of hindsight, and “*showed a total lack of insight, reflection, and understanding*”.³⁴⁹
- 2.312 In addition, the families urged me to make a number of findings in relation to the manner in which Dr Boros-Lavack gave her oral evidence and her reliability as a witness, which is addressed elsewhere in these findings.

Submissions on behalf of Dr Boros-Lavack

- 2.313 The written submissions on behalf of Dr Boros-Lavack (dated 24 October 2025) contained concessions regarding the discharge process, and stated:

³⁴⁸ Transcript, Closing Submissions D1: T1917.32-39 (25 November 2025).

³⁴⁹ Written submissions on behalf of the Good, Singleton and Young families at [4.66].

*Since concluding her oral evidence, [Dr Boros-Lavack] has had the opportunity to reflect on the oral evidence of the eminent panel of expert psychiatrists and her own initial resistance in her oral evidence to acknowledge that there were some flaws in the process whereby she discharged [Joel Cauchi] back to his referring general practitioner, Dr Grundy. I am instructed that she now does concede there were deficiencies in the manner she discharged [Joel Cauchi] from her care. They are addressed in greater detail below.*³⁵⁰

- 2.314 Those submissions on behalf of Dr Boros-Lavack further indicated that: Dr Boros-Lavack accepted that the wording of the discharge letter “*represented a missed opportunity for a more comprehensive handover*” (whilst noting this acknowledgement was belated); Dr Boros-Lavack now recognises her discharge letter to Dr Grundy should have referred to her proposal to resume antipsychotic medication in response to potential early warning signs identified by Mrs Cauchi, and should have referred to the high risk of relapse for Mr Cauchi; Dr Boros-Lavack accepts she did not update or confirm her guidance to Dr Grundy regarding that risk; as Mr Cauchi did not provide the name of a new GP in Brisbane, a direct referral was not possible, and Dr Grundy was well-versed in Mr Cauchi’s condition; and “[t]he letter to Dr Grundy was not a final discharge into a void but a handover to a trusted colleague, asking him to recall Joel to discuss his options and referral to an alternative psychiatrist if required” (with the intention of continuity of care).³⁵¹
- 2.315 It was submitted on behalf of Dr Boros-Lavack that the trigger for the termination of Mr Cauchi’s care was him moving to Brisbane and becoming ineligible for the Medicare subsidy which was sudden, unexpected and clearly undesirable as he had not yet located another suitable practitioner to take over his care.
- 2.316 Further, it was submitted on behalf of Dr Boros-Lavack that I would accept the overwhelming and unanimous expert evidence, which clearly demonstrates that Dr Boros-Lavack’s care of Mr Cauchi from 2012 to 2020 met acceptable professional standards expected of an expert psychiatrist, but for the exercise in discharging Mr Cauchi back to his GP in March 2020 (and that expert evidence was less critical than some of the submissions made).
- 2.317 Dr Boros-Lavack’s submissions refer to the following expert evidence:
- (a) Oral evidence of expert psychiatrist panel:

“LYNCH: Do you consider that the treatment provided by Dr Boros-Lavack and the Mi-Mind Centre staff met the accepted standards applicable to private psychiatrists throughout the period of 2012 to 2020? Professor Nielssen?

³⁵⁰ Written submissions on behalf of Dr Andrea Boros-Lavack at [2].

³⁵¹ Written submissions on behalf of Dr Andrea Boros-Lavack at [13.1]-[13.5].

WITNESS NIELSSEN: *I believe so. I mean it was exemplary, it was above and beyond really up until the end. It was just the, the handover was care was [sic], there were some shortcomings there.*

LYNCH: *Professor Heffernan?*

WITNESS HEFFERNAN: *No, I agree. I mean I think there was really good care for seven, eight years, maths is poor at the moment, but I think that the majority of the care was really well managed. The one area that I think could have been improved was that discharge handover.*

LYNCH: *Professor Harris?*

WITNESS HARRIS: *I agree.*

LYNCH: *Professor Large?*

WITNESS LARGE: *I think it was well within the acceptable standard of care”;*³⁵²
and

(b) Report of expert GP, Dr Wilson:

“From the information available to me, Mr Cauchi’s psychiatric management between his diagnosis in 2001 until 2019 appears to have been excellent. ... The decision to cease his medication was done diligently, slowly, with a second opinion, support and continued follow-up.

*Sadly, the ongoing collaborative psychiatric care was discontinued when Mr Cauchi chose to move to Brisbane. At this time, virtual care between Mr Cauchi and Dr Boros-Lavack was not supported by Medicare due to rules limiting specialist virtual care based on rurality and, as a result, was beyond the financial capacity for Mr Cauchi. To continue seeing Dr Boros-Lavack he would need to travel to Toowoomba to do so. Dr Boros-Lavack ended care by transferring his care back to his Toowoomba GP. This is an accepted and common process”.*³⁵³

2.318 It was submitted on behalf of Dr Boros-Lavack that she did respond adequately to the early warning signs raised by Mrs Cauchi; the evidence strongly suggests she did “*place sufficient weight*” on Mrs Cauchi’s concerns; and on the unchallenged evidence, Dr Boros-Lavack did have a high index of suspicion for signs of relapse.

2.319 Further, it was submitted that Dr Boros-Lavack clearly recognised warning signs in late 2019 and that:

The consistent evidence of [Dr Boros-Lavack] was that she did accept that Mrs Cauchi’s concerns were “early warning signs of relapse”.

³⁵² Transcript, D16 (Nielssen/Heffernan/Harris/Large): T1497.34-T1498.5 (22 May 2025).

³⁵³ Exhibit 1, Expert Volume, Tab 4, Expert Report of Dr Hester Wilson, p. 21 at lines 484-494.

...

That 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.

2.320 It was submitted on behalf of Dr Boros-Lavack that the clinical notes do not disclose the extent of any efforts of Dr Boros-Lavack to encourage Mr Cauchi to resume medication and it is difficult to measure the following criticism by Professor Nordentoft: *"In conclusion, in the months after Mr Cauchi was taken off aripiprazole [sic], there were some signs of emerging relapse, the psychiatrist paid some attention to that, but there was very little assertiveness regarding getting him back on medication"*.

2.321 It was submitted on behalf of Dr Boros-Lavack that when she saw Mr Cauchi, she *"thought the signs of psychosis were not present"*, she *"concluded that other concerns were likely to be the causes of his stress, including his concern that he'd contracted HIV ..."*, and that:

In circumstances where [Dr Boros-Lavack] thought that the early warning signs which she acknowledged were likely attributable to his reaction to the "dangerous sexual encounter" and his fears of having contracted HIV, that is understandable in the absence of any recognition on both her own and RN Brooks' assessments, that his psychosis had resumed. [Mr Cauchi] was a voluntary patient with capacity to decide for himself whether or not he would resume antipsychotic medication. Without the benefit of hindsight as to the shocking violence displayed by [Mr Cauchi], 4 years afterwards, it seems unduly harsh to criticise [Dr Boros-Lavack] for limited "assertiveness" in all the circumstances.

2.322 It was submitted on behalf of Dr Boros-Lavack that Counsel Assisting's criticism regarding her clinical notes is not relevant and beyond the scope of the Inquest and that without expert evidence, I would be reluctant to make a finding regarding any deficiency in the records.

2.323 As summarised earlier in this Part, it was submitted on behalf of Dr Boros-Lavack that there are multiple complex reasons that Mr Cauchi was lost to mental health follow-up. It was also submitted that Counsel Assisting's submission that Dr Boros-Lavack's alleged failure was a *"major reason"* Mr Cauchi was lost to mental health follow-up is an oversimplification of the reasons he was lost to follow-up, that he was not lost to mental health follow-up for the entire four year period after Mi-Mind Centre, and that no practitioner who saw Mr Cauchi after Mi-Mind Centre ever considered Mr Cauchi was a risk to himself or others. It was submitted on behalf of Dr Boros-Lavack that: *"I think the weight of expert evidence clearly points to the fact that he was deteriorating by late 2023 and certainly by 2024"*.

2.324 It was submitted on behalf of Dr Boros-Lavack that Mrs Cauchi's correspondence to Dr Boros-Lavack dated 3 May 2024 is reflective of a positive therapeutic relationship.

- 2.325 It was also submitted on behalf of Dr Boros-Lavack that the expert evidence indicated Mr Cauchi never reached the threshold whilst at Mi-Mind Centre to be made an involuntary patient or to be compelled to take medication and that he decided not to resume the medication prescribed by Dr Boros-Lavack “*despite the advice to the contrary*”.

Findings

- 2.326 Once again, as with all of my findings in this Part, I give significant weight to the expert evidence as the basis upon which my findings are made.
- 2.327 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.
- 2.328 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.
- 2.329 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

- 2.330 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.
- 2.331 As set out earlier in these findings, 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.
- 2.332 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.”

2.333 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.

2.334 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.

2.335 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.

2.336 The key events were as follows:

(a) On 20 November 2019, Mrs Cauchi contacted 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”*.

- (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 managing [sic] well and to continue with his holiday and start med if EWS appears".

- 2.337 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 (as set out above).
- 2.338 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.
- 2.339 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.
- 2.340 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.

- 2.341 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.
- 2.342 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.
- 2.343 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).
- 2.344 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).
- 2.345 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.
- 2.346 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.
- 2.347 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

- 2.348 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, as submitted by Counsel Assisting.
- 2.349 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.
- 2.350 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.

- 2.351 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.
- 2.352 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.
- 2.353 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.
- 2.354 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.
- 2.355 In those written submissions, it is conceded on behalf of Dr Boros-Lavack 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 was involved at the time of discharge, and I consider that it was a serious missed opportunity.
- 2.356 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.

- 2.357 As noted earlier in these findings, 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.
- 2.358 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.
- 2.359 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.

Referral to Health Ombudsman of Queensland

- 2.360 It was submitted on behalf of the Good, Singleton and Young families that I should make a referral to the Health Ombudsman of Queensland (pursuant to sections 138, 144 and 145 of the *Health Practitioner Regulation National Law (Queensland) 2009*) with respect to Dr Boros-Lavack.³⁵⁴
- 2.361 On behalf of Dr Boros-Lavack, it was submitted that such a referral is not warranted and that it is open to the families to seek investigation by a disciplinary authority directly if they wish to do so.³⁵⁵
- 2.362 Counsel for the Good, Singleton and Young families submitted that the families should not have to personally participate in such a process following this Inquest, when a referral can and should be made by me.³⁵⁶
- 2.363 Counsel Assisting submitted that it is open to me to make a referral of Dr Boros-Lavack to the Health Ombudsman of Queensland.³⁵⁷
- 2.364 Section 82 of the *Coroners Act 2009* relevantly provides that I may make a recommendation, if I consider it to be necessary or desirable, "*that a matter be investigated or reviewed by a specified person or body*" (per s. 82(1) and 82(2)(b)).
- 2.365 I have closely considered the submissions on behalf of the families and Dr Boros-Lavack regarding this issue.
- 2.366 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

³⁵⁴ Written submissions on behalf of the Good, Singleton and Young families at [4.87].

³⁵⁵ Transcript, Closing Submissions D2: T1988.10-18 (28 November 2025); Written submissions on behalf of Dr Boros-Lavack at [19.1]-[19.20].

³⁵⁶ Transcript, Closing Submissions D2: T2010.35-43 (28 November 2025).

³⁵⁷ Transcript, Closing Submissions D2: T1917.32-47 (25 November 2025); Transcript, Closing Submissions D2: T2024.24-27 (28 November 2025).

Cauchi was reporting concerns) and the discharge process including, in particular, Dr Boros-Lavack's discharge letter dated 19 March 2020.

2.367 Accordingly, I make the following recommendation per s. 82(1) and (2)(b) of the Act:

RECOMMENDATION

Recommendation 1: To the Health Ombudsman of Queensland

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

E. Treatment from GP Dr Grundy

- 2.368 As referred to above, Dr Grundy was Mr Cauchi's treating GP from 2001 to 2019. He was primarily involved in treating physical illnesses, while Mr Cauchi's complex mental health concerns were dealt with by the public mental health sector and then Dr Boros-Lavack.

Standard of care provided by GP Dr Grundy (approx. 2001 to 2019)

Expert evidence

- 2.369 In terms of the general care provided to Mr Cauchi by Dr Grundy, the evidence of the expert GPs included the following:

(a) Dr Wilson:

"Dr Grundy and his practice did not manage Mr Cauchi's schizophrenia as this was managed by specialist mental health staff at the CMHC. However, he was seen for various self-limiting and acute illnesses in the practice, and the treatment of these were clinically appropriate. The GPs in the practice were aware of Mr. Cauchi's clozapine use and the risk associated with this. Dr Grundy and other GPs at the Centre undertook blood tests and heart screens on a regular basis to support the safe prescribing of clozapine. Regular referrals for specialist psychiatric care were made for Mr Cauchi throughout the time he was seen at this GP practice.

*Dr Grundy last saw Mr Cauchi in August 2019. From the information available to me, Dr Grundy's management was adequate and appropriate."*³⁵⁸

(b) Dr Kruys:³⁵⁹

- i. *"In my opinion, the treatment provided by Dr Grundy was appropriate.*

There is room for improvement in interprofessional coordination of physical and mental health care delivery between general practice teams and specialist mental health care teams to ensure people living with a mental health condition receive adequate, longitudinal care";

- ii. As noted above, Dr Kruys opined: *"Although discharge back to the referring GP is formally an appropriate action, the outcome of appropriate follow-up care was doubtful in this case, as Mr Cauchi had already left town";* and

³⁵⁸ Exhibit 1, Expert Volume, Tab 4, Expert Report of Dr Hester Wilson at p. 19, lines 420-428.

³⁵⁹ Exhibit 1, Expert Volume, Tab 6, Expert Report of Dr Edwin Kruys at [1]-[2], [24].

- iii. As outlined above, Dr Kruys opined that there appears to be a missed opportunity for the GP team “to assist Mr Cauchi with follow-up care by a GP and/or psychiatrist in the Brisbane area. It is acknowledged that this step is not routinely part of the care when not requested by the patient but could have been considered given Mr Cauchi’s mental health history and the risk associated with no follow up care”.

2.370 The evidence of the expert GPs in terms of the discharge process is addressed earlier in this Part.

Submissions

2.371 Counsel Assisting submitted:

*Dr Grundy should have taken a more proactive approach with Mr Cauchi’s care at the time he was discharged back to his clinic, and he had some responsibility for the poor communication that resulted. Given the lack of clarity in the final letter from Dr Boros-Lavack, Dr Grundy should have recalled Mr Cauchi and attempted to assist him, and could and should have called Dr Boros-Lavack to ask her for more information about the risk to Mr Cauchi at that time.*³⁶⁰

2.372 Counsel Assisting also submitted that there appears to be an earlier missed opportunity for Dr Grundy to have been more proactive on 14 March 2019, when he saw Mr Cauchi and noted: “Requests plan to access Psychology to get some counselling [sic]. Checking out options. Will think about this”.³⁶¹

2.373 However, Counsel Assisting submitted that the Court would not be overly critical of Dr Grundy in the circumstances, for the following reasons: I could not be satisfied there was any conversation between Dr Grundy and Dr Boros-Lavack and even if that did occur, Dr Boros-Lavack would not have passed on the serious concerns; Dr Boros-Lavack as the psychiatrist was responsible for managing Mr Cauchi’s complex mental health condition; the letters from Dr Boros-Lavack to Dr Grundy over many years represented that Mr Cauchi was free of the positive symptoms of schizophrenia; Dr Boros-Lavack did not refer to early warning signs of relapse in the discharge letter; and Dr Grundy had limited means to provide any service to Mr Cauchi who moved to Brisbane during the COVID-19 pandemic.

2.374 Further, Counsel Assisting submitted that the issue of most significance was that Dr Grundy (like other practitioners from 2020 to 2023) was not provided the information that would have mandated a re-call of Mr Cauchi.

³⁶⁰ Written submissions of Counsel Assisting at [395].

³⁶¹ See Exhibit 1, Vol 19, Tab 788, St Andrews Medical Centre medical records at p. 4.

2.375 It was submitted on behalf of Dr Grundy, in summary, that:³⁶²

- (a) Expert GPs Dr Wilson and Dr Kruys both opined that Dr Grundy's treatment of Mr Cauchi was appropriate, and also that Dr Grundy was not responsible for Mr Cauchi's chronic mental health care.
- (b) Whilst Dr Kruys raised a systemic issue regarding interprofessional coordination between GP teams and specialist mental health teams, Dr Kruys does not suggest that Dr Grundy's individual care of Mr Cauchi failed in this regard.
- (c) Whilst Counsel Assisting submits Dr Grundy could have been more proactive and taken some responsibility for the poor communication that resulted, *"neither Dr Wilson or Dr Kruys is overly critical of Dr Grundy for not making contact with Dr Boros-Lavack given he was not managing Mr Cauchi's mental illness, nor do they suggest a general practitioner should"*.
- (d) Professor Nielssen's opinion should be preferred, in that *"the medical profession relies on patients to seek treatment themselves, cautioning against a standard or "council of perfection to expect" that the medical profession will in essence 'chase' its patients with mental illness for review and treatment. This opinion clearly reflects the practise of 'real life medicine' and a patient's autonomy as to the nature and extent of the treatment they seek"*.
- (e) Dr Grundy adopts Counsel Assisting's submission that the circumstances of the discharge from Dr Boros-Lavack to Dr Grundy were *"wholly unsatisfactory"*, and that Dr Boros-Lavack did not pass on information which was her responsibility to do.
- (f) Dr Grundy adopts Counsel Assisting's six reasons for tempering of any criticism of Dr Grundy's lack of response to Dr Boros-Lavack's discharge letter. However, further to that, it is submitted on behalf of Dr Grundy that: *"Dr Grundy [challenges] whether any criticism at all is warranted. That is particularly so noting the submission made by Counsel Assisting ... namely, Dr Grundy's complete ignorance of the reported history by Mrs Cauchi of early warning signs of relapse from late 2019 onwards ..."*.
- (g) The absence of any information, let alone critical information, was the fundamental flaw in the handover of care from Dr Boros-Lavack to Dr Grundy in March 2020. Dr Boros-Lavack failed to include any of the information that the combined expert opinion indicated was required (at a minimum) for effective handover of care, namely: discharge diagnosis; whether his schizophrenia was in remission; details of any ongoing treatment and management plan; factors and concerns regarding relapse (noting the source of the concerns could remain unidentified); and the rationale behind the cessation of psychotropic medication and the risks and benefits. It was submitted on behalf of Dr Grundy

³⁶² Written submissions on behalf of Dr Grundy, Dr Ruge and Dr Parkar at [10]-[22].

that Dr Boros-Lavack's post-hearing concessions recognised that most of these requirements were absent from the letter.

- (h) Another fundamental problem with the discharge letter was the ambiguity in language used as to whether there was a need for ongoing psychiatric care and if so, whether Mr Cauchi or Dr Grundy was to instigate that. The discharge letter stated (emphasis per submissions): *"Please recall Joel to discuss his options and referral to an alternative psychiatrist if required".*
- (i) Dr Grundy's decision not to re-call Mr Cauchi was also based on eight years of correspondence from Dr Boros-Lavack (approximately 20 letters) *"which never raised any mental state deterioration, relapse or red flags"* and *"[t]he tenor of all correspondence was that Mr Cauchi was in remission and doing 'very well' or 'excellent'. It was self-evident from all correspondence that Mr Cauchi was both fully compliant and engaged with his treatment plan ..."*
- (j) The unanimous view of the medical experts was that Mr Cauchi did not present in a manner warranting involuntary hospital admission at any time he was seen by medical practitioners (which would include Dr Grundy).

2.376 Counsel Assisting agreed with the submissions made on behalf of Dr Grundy.

Findings

- 2.377 I accept that the overall care provided by Dr Grundy to Mr Cauchi was adequate, reasonable and appropriate.
- 2.378 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"*.
- 2.379 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).
- 2.380 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.

F. Care after Mi-Mind Centre (March 2020 onwards)

- 2.381 Following Mr Cauchi's discharge from Mi-Mind Centre, Mr Cauchi had a further appointment on 22 April 2020 at Cannon Hill Family Doctors, although he saw a different GP to the time prior. The STI test results from 18 March 2020 were discussed at that appointment.³⁶³

Treatment from GP Dr Ruge (2020 to 2021)

- 2.382 From 27 May 2020 to 30 April 2021, Mr Cauchi saw GP, Dr Nathan Ruge on a number of occasions, at Brisbane GP and Travel Doctor and also at MyLocalDoc Chermside.³⁶⁴ Mr Cauchi also saw another GP at Brisbane GP and Travel Doctor twice, in early 2021.³⁶⁵ Details of relevant appointments with Dr Ruge are set out below.

- 2.383 On 27 May 2020 and 2 June 2020, Dr Ruge saw Mr Cauchi via telehealth (phone) to request STI testing and receive those results. On 2 June 2020, Dr Ruge noted:

*[I]ncidentally, Joel discloses a prior history of schizophrenia
nil specialist follow up since moving to Brisbane from [Toowoomba]
has not been on medication for over [18 months] now feeling well though
no active perceptual disturbance or formal thought disorder
No suicidal ideation
Nil pervasive mood disturbance
Generally enjoys a good outlook on life with new living arrangements, [commencement
of work] and study ([English] teaching) locally...³⁶⁶*

- 2.384 On 15 June 2020, Dr Ruge saw Mr Cauchi via telehealth (phone). Dr Ruge referred Mr Cauchi to a private psychiatrist, Dr Rob Moyle, as requested by Mr Cauchi. The notes also include:

*Discussed schizophrenia further with me today
... He is not taking [any regular] medications presently. He denies any active
symptoms.³⁶⁷*

- 2.385 On 20 July 2020, Dr Ruge saw Mr Cauchi via telehealth (phone) requesting an STI screen.³⁶⁸

- 2.386 On 17 August 2020, Dr Ruge saw Mr Cauchi, who requested to be referred to a psychiatrist who bulk-billed, rather than Dr Moyle. Dr Ruge wrote a new referral letter to "The Psychiatrist" at Belmont Private Hospital. On 25 August 2020, Belmont Private

³⁶³ Exhibit 1, Vol 22, Tab 801, Cannon Hill Family Doctors medical records at pp. 2-3; Exhibit 1, Vol 22, Tab 801A, Letter from Dr Kanchana Ranasinghe.

³⁶⁴ See Exhibit 1, Vol 26, Tab 951, Medicare Patient History Report for period dated 1 July 2019 – 13 April 2024 at pp. 6-8.

³⁶⁵ See Exhibit 1, Vol 27, Tab 952, PBS Patient Summary for period dated 1 July 2019 – 13 April 2024. See also: Exhibit 1, Vol 22, Tab 802, Statement of Dr Nathan Ruge; Exhibit 1, Vol 22, Tab 803A, Better Medical records.

³⁶⁶ Exhibit 1, Vol 22, Tab 803, MyLocalDoc GP medical records at pp. 2-3; Exhibit 1, Vol 22, Tab 803A, Better Medical records at pp. 4-5.

³⁶⁷ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at p. 5.

³⁶⁸ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at p. 5.

Hospital contacted Dr Ruge's practice and indicated they would archive the referral as they had been unable to contact Mr Cauchi regarding group sessions.³⁶⁹

- 2.387 On 11 September 2020, Mr Cauchi saw another GP at Woolloongabba Medical Centre for a physical health concern.³⁷⁰
- 2.388 On 4, 8 and 14 September 2020, Dr Ruge saw Mr Cauchi for physical health concerns. On 4 September 2020, Mr Cauchi also requested STI testing.³⁷¹
- 2.389 On 21 September 2020, Dr Ruge saw Mr Cauchi and completed a GP Management Plan. Mr Cauchi also requested a referral to a new psychiatrist. Accordingly, Dr Ruge wrote referral letters to Dr Amitava Sarkar, and a psychiatrist at Oxford Clinic, which both provided:

Thank you for seeing Joel Cauchi, age 37 yrs, for an opinion and management regarding [schizophrenia]. This first [manifested] for him aged 17 with tactile hallucinations and disorder of thought. He reports it was closely [related] to excessive use of drugs at the time. He has been following up monthly with his previous psychiatrist in Toowoomba, Dr Andrea Boros-Lavack until recently. Given the distance between them now, this therapeutic relationship is no longer tenable. He is not taking [any regular] medications presently. He denies any active symptoms.

³⁷²

- 2.390 On 23 November 2020, Dr Ruge saw Mr Cauchi again via telehealth (phone). According to Dr Ruge's notes, Mr Cauchi was doing well, requested STI testing, and:

Stil [sic] denies any active symptoms of previously diagnosed [schizophrenia] and no pervasive mood disturbance

Joel requests today's [consult] for consideration of a medical certificate clearing him medically to hold a gun license

Joel says he has an appointment with the psychiatrist I last referred him to (Dr Sarkar) this Thursday

[Advised] that, [given] his request for psychiatrist review, and and [sic] concern for [schizophrenia] diagnosis impact on candidacy for holding a gun license, advised he discuss the matter [with him]

...

*Review with Psychiatrist for further assessment and management of schizophrenia and ?candidacy on medical ground to hold a gun [licence]...*³⁷³

- 2.391 As expanded on below, Dr Ruge received reporting letters from psychiatrists Dr Sarkar on 26 November 2020 and Dr Parkar on 18 or 19 January 2021.³⁷⁴

³⁶⁹ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at pp. 5-6.

³⁷⁰ Exhibit 1, Vol 22, Tab 804, Woolloongabba Medical Centre medical records at pp. 2-3.

³⁷¹ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at pp. 6-7.

³⁷² Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at pp. 7-8, 34-35; Exhibit 1, Vol 22, Tab 806, Cornwall Street Medical Centre medical records at p. 4.

³⁷³ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at pp. 7-8.

³⁷⁴ Exhibit 1, Vol 22, Tab 805, Statement of Dr Amitava Sarkar at [2.4]-[2.9]; Exhibit 1, Vol 22, Tab 808, Oxford Clinic medical records at pp. 4-6.

2.392 On 1 February 2021, Dr Ruge saw Mr Cauchi via telehealth (phone). Mr Cauchi requested STI testing and a Valium prescription for stress.³⁷⁵ The STI testing was arranged, which was ultimately negative.³⁷⁶ On 24 March 2021, Dr Ruge saw Mr Cauchi for a physical health concern.³⁷⁷

2.393 On 30 April 2021, Dr Ruge saw Mr Cauchi, including in relation to his driver licence. Dr Ruge's notes record that:

A conditional licence may be considered for Joel given the following criteria are met:

- *the condition is well controlled and the person is compliant with treatment over a substantial period; and*
- *the person has insight into the potential effects of their condition on safe driving; and*
- *there are no adverse medication effects that may impair their capacity for safe driving...*³⁷⁸

2.394 In his oral evidence, Dr Ruge indicated that during the consultation on 30 April 2021, he performed a cursory mental state examination of Mr Cauchi for any active symptoms of schizophrenia which may have impacted his driving, such as perceptual disturbances or visual or auditory hallucinations.³⁷⁹ Mr Cauchi denied these symptoms and Dr Ruge considered that he met the eligibility criteria.³⁸⁰

2.395 Dr Ruge acknowledged that his notes of the appointment were insufficient, particularly as they did not record that a mental state examination had been conducted.³⁸¹ He also acknowledged that if he had known about Mr Cauchi's history of erratic driving (addressed elsewhere in these findings), he would have explored that directly with Mr Cauchi during the consultation; been unlikely to have signed off on his medical certificate; and would have relayed that information to Mr Cauchi's treating psychiatrist.³⁸²

2.396 Following that 30 April 2021 appointment, 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.³⁸³ He saw another GP (Dr John Pietsch), also in relation to his driver licence, on one occasion on 13 November 2023 as set out below.

Standard of care provided by Dr Ruge

2.397 Dr Wilson opined that:

Dr Ruge's assessments were generally excellent with comprehensive assessment and plans. He was aware of Mr Cauchi's mental health issues and repeatedly asked about

³⁷⁵ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at p. 8.

³⁷⁶ Exhibit 1, Vol 22, Tab 802A, Statement of Dr Celeste Burgoyne at [12]-[15].

³⁷⁷ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at p. 10.

³⁷⁸ Exhibit 1, Vol 22, Tab 803A, Better Medical records (including Brisbane GP and Travel Doctor) at p. 10.

³⁷⁹ Transcript, D12 (Ruge): T1073.49-T1074.6 (14 May 2025).

³⁸⁰ Transcript, D12 (Ruge): T1073.16-21 (14 May 2025).

³⁸¹ Transcript, D12 (Ruge): T1074.12-18 (14 May 2025).

³⁸² Transcript, D12 (Ruge): T1074.20-38 (14 May 2025).

³⁸³ See Exhibit 1, Vol 26, Tab 951, Medicare Patient History Report.

*Mr Cauchi's mental health. On the basis of his assessments and feedback from Drs Sarkar and Parkar there was little reason for Dr Ruge to be concerned regarding Mr Cauchi's stability... Dr Ruge's management was adequate and appropriate.*³⁸⁴

2.398 Dr Kruys opined: *"In my opinion, the treatment provided by Dr Ruge was adequate and appropriate"*.³⁸⁵

2.399 Counsel Assisting submitted, with reference to the 30 April 2021 appointment: *"The Court would appreciate the reflections of Dr Ruge, who impressed as a thoughtful, and skilled practitioner"*.³⁸⁶ Counsel Assisting also submitted that I would accept the written submissions made on Dr Ruge's behalf.³⁸⁷

2.400 Counsel for Dr Ruge submitted as follows:³⁸⁸

- (a) Counsel Assisting's submission that Dr Ruge *"impressed as a thoughtful, and skilled practitioner"* is *"clearly established on the evidence..."*;
- (b) *"Professor Large recognised the difficulty Dr Ruge had in taking over Mr [Cauchi's] care given he did not have the full clinical picture ..."*; and
- (c) Dr Wilson's expert opinion included that Dr Ruge's assessments were generally *"excellent with comprehensive assessment and plans"*. This is consistent with Dr Kruys' expert opinion, who also noted that Dr Ruge prepared a GP care plan which incorporated mental health-related goals.

Findings

2.401 I accept the evidence of the experts as well as the submissions made on Dr Ruge's behalf.

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

Consultation with psychiatrists Dr Sarkar and Dr Parkar (2020 and 2021)

2.403 After ceasing care at Mi-Mind Centre, Mr Cauchi only saw two psychiatrists, being Dr Amitava Sarkar (at Cornwall Street Medical Centre) and Dr Sagir Parkar (at Oxford Clinic). This occurred in late 2020 to early 2021. Mr Cauchi saw each psychiatrist on only one occasion and requested from each a report to support a "gun licence" or an application to use a gun at a gun range.

³⁸⁴ Exhibit 1, Expert Volume, Tab 4, Expert Report of Dr Hester Wilson at p. 20, lines 464-468.

³⁸⁵ Exhibit 1, Expert Volume, Tab 6, Expert Report of Dr Edwin Kruys at [26].

³⁸⁶ Written submissions of Counsel Assisting at [445].

³⁸⁷ Transcript, Closing Submissions D1: T917.49-50 (25 November 2025).

³⁸⁸ Written submissions on behalf of Dr Grundy, Dr Ruge and Dr Parkar at [24]-[26].

Dr Sarkar (November 2020)

- 2.404 First, on 26 November 2020, Mr Cauchi saw Dr Sarkar at Cornwall Street Medical Centre in Brisbane and requested a report for a “gun licence”. Mr Cauchi left before the assessment could be completed. Dr Sarkar’s report (as faxed to Dr Ruge on the same date) included the following:

... He says he is going well for his mental health.

He says he wants a gun licence to use for sport and hence needs a report for that.

He had been interested in shooting for 6 months and wants to go camping for shooting targets.

He is not very clear about the whole plan. He will be doing a course to be able to do that. He has not visited the club yet and vaguely knows its location.

...

He was put on medication for Schizophrenia Clozapine 600mg at age of 17, He came off it in 2018. Now on no medication for 2 years. He had used marijuana before onset.

He had confusion as a symptom and struggles to tell about his other morbid experiences.

He has poor eye contact and uses stock words, he may be guarded or have poverty of content of thought and speech. Affect is restricted. He does not seem to have hallucinatory behaviour, he took off well before I could finish my assessment.

He is aware that I require his previous psychiatric reports to make any decision about future treatment or document towards getting gun licence for the first time.

My general view is that he may be having Autism spectrum disorder when he could have unusual psychiatric experiences and especially on illicit drugs. He does not come across as a typical patient with Schizophrenia who is off psychotropic drugs.³⁸⁹

- 2.405 On 2 December 2020, the Mi-Mind Centre receptionist provided Dr Sarkar with four letters regarding Mr Cauchi (in response to a request on 26 November 2020 for Mr Cauchi’s medical records).³⁹⁰ In her first statement, Dr Boros-Lavack described that as “comprehensive collateral information” provided. The four letters were:

- (a) Letter from Dr Boros-Lavack to Dr Grundy dated 12 June 2019. This relates to Mr Cauchi ceasing Abilify and being on no psychotropic medication; him being “totally well with remission of his psychosocial disability” since ceasing Clopine a year prior; and states the “[o]nly problem” is residual complex tics;
- (b) Letter from Dr Boros-Lavack to Dr Grundy dated 3 May 2018. This letter refers to Mr Cauchi being mentally “good”, although with physical concerns and a “wide based gait”, and that the plan was to cease Clopine in June;
- (c) Letter from Dr Boros-Lavack to Dr Grundy dated 5 April 2018. In this letter, Dr Boros-Lavack states “[b]est I have seen him” and that Mr Cauchi was happy,

³⁸⁹ Exhibit 1, Vol 22, Tab 805, Statement of Dr Amitava Sarkar at [2.4]-[2.9].

³⁹⁰ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 27-28, 33-34, 126; Exhibit 1, Vol 19, Tab 806, Cornwall Street Medical Centre medical records at pp. 8-12, 15, 18-21.

apsychotic, and finding it difficult to cease Clopine and wanting to do so more slowly; and

- (d) Letter from Dr Boros-Lavack to Dr Grundy dated 6 March 2012. This relates to Mr Cauchi's first appointment with Dr Boros-Lavack; provides that Mr Cauchi's illness had been "*in control on Clozapine for the past 10 years or so*"; and provides the DSM-IV diagnosis which includes: "*Chronic Paranoid & Disorganised Schizophrenia. In control on Clopine. OCD*".

2.406 Accordingly, Dr Sarkar was not provided the discharge letter from Dr Boros-Lavack to Dr Grundy dated 19 March 2020.

2.407 Whilst Dr Sarkar does not recall reviewing those documents, he gave evidence that their contents would not have caused him to change his risk assessment. Mr Cauchi did not schedule a further appointment with Dr Sarkar.³⁹¹

Standard of care provided by Dr Sarkar

2.408 Professor Harris, referring to both Dr Parkar and Dr Sarkar, noted that neither of the private psychiatrists that saw Mr Cauchi offered ongoing care for his schizophrenia, despite Dr Ruge requesting that in his letter of referral.³⁹² Further, the amount of information provided by Mi-Mind Centre to Dr Sarkar was undoubtedly "*inadequate*".³⁹³

2.409 Professor Heffernan identified the assessment by Dr Sarkar as an opportunity to "*re-engage Mr Cauchi in treatment and care in a pro-active manner*".³⁹⁴ Further, Professor Heffernan commented that he would have found the information provided by Mi-Mind Centre to Dr Sarkar "*quite confusing*".³⁹⁵

2.410 Counsel Assisting submitted that in the circumstances of Dr Sarkar's one-off assessment with Mr Cauchi on his own, there was no opportunity for Dr Sarkar to gain a true understanding of Mr Cauchi's psychiatric risk profile or functioning at that time. Counsel Assisting submitted that whilst on one view this was a missed opportunity to assess Mr Cauchi and link him back to support services, no criticism should be made of Dr Sarkar, who was not provided with the information held by Dr Boros-Lavack regarding signs of Mr Cauchi's mental health deterioration from at least October 2019 and as Mr Cauchi left the appointment before it was completed.

2.411 Counsel Assisting submitted there is also little weight that could be given to Dr Sarkar's assessment of Mr Cauchi (which is not a criticism of Dr Sarkar), given the assessment was not completed.³⁹⁶

³⁹¹ Exhibit 1, Vol 22, Tab 805, Statement of Dr Amitava Sarkar at [2.8]-[2.9], [2.12].

³⁹² Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [5.2]

³⁹³ Transcript, D16 (Harris): T1474.27-T1475.4 (22 May 2025).

³⁹⁴ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [7.2.3].

³⁹⁵ Transcript, D16 (Heffernan): T1474.19-27 (22 May 2025).

³⁹⁶ Written submissions of Counsel Assisting at [416].

- 2.412 I accept these submissions of Counsel Assisting with respect to Dr Sarkar's care of Mr Cauchi.
- 2.413 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.
- 2.414 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.

Dr Parkar (January 2021)

- 2.415 On 18 January 2021, Dr Parkar saw Mr Cauchi at the Oxford Clinic in Brisbane.³⁹⁷ Per Dr Parkar's notes of the consultation (which were created on 18 January 2021 and finalised on 28 January 2021 after receiving correspondence from the Mi-Mind Centre):

... Today's review for the purpose of medical fitness so that he can visit a gun range and practise target shooting.

Does not own guns, last time he went to a range was when he was 25 yrs old.

Does not have a gun license. No friends or family members own firearms.

Currently reports stable mental state.

Good, stable mood.

Nil hallucinations or psychotic symptoms.

Denied problems with memory or functioning.

Currently studying to become an English teacher.

Does not work

In receipt of DSP after being diagnosed with schizophrenia at the time of his initial admission in 2000.

Eating regularly. no problems with appetite.

No problems reported with sleep.

Denied thoughts of self harm, suicidal ideation or thoughts to harm others.

Some twitching of the mouth noted, which Joel reported to be due to nervousness.

Had been seeing Dr Boros-Lavack at Toowoomba privately for monthly follow up sessions.

Reports he has had psychotic episode at the age of 17 yrs, experienced tactile hallucinations then after smoking cannabis for over a year.

Admitted to Tmba adolescent ward.

States he was started on Clozapine and then after a couple of years was transitioned to Aripiprazole, which he continued for appro [sic] 16 years.

Been off Abilify for the past 18 months.

No relapse in psychotic symptoms noted.

Denied forensic history.

Denied recent or current drug use. States last drug use was prior to hospital admission.

³⁹⁷ Transcript, D13 (Parkar): T1136.14-18 (15 May 2025).

Nil acute medical problems.

...

Reports No known family history of schizophrenia.

Currently not on medication.

Impression -

Presents with stable mental state.

No acute psychotic symptoms.

Unsure why he was seeing a psychiatrist monthly for the past 18 months if he was not on medication.

Plan -

to keep referral open in case he requires further follow up reviews.

Seek collateral information from T'mba

...³⁹⁸

2.416 Dr Parker did not contact Mrs Cauchi to obtain collateral information. He noted that Mr Cauchi had specifically selected in the consent form provided to the clinic that Mrs Cauchi was not to be contacted other than in an emergency.³⁹⁹

2.417 Dr Parker's evidence was that his usual practice was to ask a patient before they leave the consulting room to make an appointment at the front desk for a follow-up, and that he did advise Mr Cauchi to make an appointment with him for a further follow-up review in six months.⁴⁰⁰

2.418 On 18 or 19 January 2021, Dr Parker wrote a letter to Dr Ruge regarding the appointment with Mr Cauchi. The letter refers to a "possibility" that Mr Cauchi's diagnosis "could be schizophrenia rather than drug-induced psychosis" and that:⁴⁰¹

(a) *"Joel informs me that today's assessment was in order to obtain a medical report/certificate on his current mental state and risk so that he can provide it to the local gun range where he wishes to practise target shooting under supervision once a week or once a fortnight.*

He reports that he does not own a gun, does not hold a gun license and will have access to guns that are owned and registered by the gun range for the duration of his practise ...";

(b) *"With regards to firearm usage, Joel reported that he last visited a gun range at the age of 25 years. He currently does not own guns or other firearms. He does not have a gun license and denied any of his friends or family members owning firearms ...";*

(c) He was initially diagnosed with schizophrenia aged 17 years;

³⁹⁸ Exhibit 1, Vol 22, Tab 808, Oxford Clinic medical records at pp. 1-2.

³⁹⁹ Transcript, D13 (Parker): T1149.27-35 (15 May 2025).

⁴⁰⁰ Transcript, D13 (Parker): T1143.2-7 (15 May 2025).

⁴⁰¹ Exhibit 1, Vol 22, Tab 808, Oxford Clinic medical records at pp. 4-6.

- (d) *“More recently Joel reports seeing Dr Boros-Lavack at Toowoomba privately for monthly follow up sessions until 12-18 months ago.
He reports being off Abilify for the past 18 months.
No relapse in psychotic symptoms reported during that time period. This has been corroborated by correspondence from Dr Boros-Lavack’s offices ...”;*
- (e) *“His level of risk to himself and others is low ...”; and*
- (f) *“Plan –
I have advised him to have 6-monthly reviews to monitor for mental state even though he is currently asymptomatic. This is in part due to him being on Clozapine for many years and the possibility that his diagnosis could be Schizophrenia rather than drug-induced psychosis.

He does not require any psychotropic medication at present”.*

2.419 It appears that on 19 January 2021, the Mi-Mind Centre’s Practice Manager provided collateral information (being seven letters) to Dr Parkar.⁴⁰² The covering letter from Mi-Mind Centre refers to a phone call that morning, which Dr Parkar gave evidence was a call with someone from Mi-Mind Centre other than Dr Boros-Lavack (as she was on another call at the time).⁴⁰³

2.420 The letters provided to Dr Parkar appear to be slightly different than the letters provided to Dr Sarkar. The seven letters provided to Dr Parkar were:

- (a) Letter to Dr Grundy dated 19 March 2020. This is the discharge letter from Dr Boros-Lavack;
- (b) Letter from Dr Boros-Lavack to Dr Grundy dated 12 June 2019 (as set out above);
- (c) Letter from Dr Boros-Lavack to Dr Grundy dated 3 May 2018 (as set out above);
- (d) Letter from Dr Boros-Lavack to Dr Grundy dated 5 April 2018 (as set out above);
- (e) Letter from Dr Boros-Lavack to Dr Grundy dated 24 January 2018. This refers to Mr Cauchi being mentally “excellent” but physically fatigued and with chronic fatigue and fainting, with a plan to continue clozapine and Abilify; and
- (f) Letter from Dr Boros-Lavack to Dr Grundy dated 11 January 2018. This refers to Mr Cauchi being well and not psychotic, and a plan to reduce Clopine down from 50 to 25mg nocte and continue with Abilify.

2.421 The letter from Dr Boros-Lavack to Dr Grundy dated 6 March 2012 (which includes the DSM-IV diagnosis) was not provided to Dr Parkar, although that was provided to Dr Sarkar.

⁴⁰² Exhibit 1, Vol 22, Tab 808, Oxford Clinic medical records at pp. 4-6.

⁴⁰³ Transcript, D13 (Parkar): T1147-1148 (15 May 2025).

- 2.422 On 20 January 2021, Dr Parkar wrote a letter titled “Medical certificate”, addressed “*To whom it may concern*”, in support of Mr Cauchi’s Statement of Eligibility application.⁴⁰⁴ That is addressed further in Part 3 of these findings.

Standard of care provided by Dr Parkar

- 2.423 Professor Harris commented that Dr Parkar did not offer Mr Cauchi ongoing care for his schizophrenia, despite the request of Dr Ruge for this in his letter of referral.⁴⁰⁵ Professor Harris identified the assessment by Dr Parkar as an opportunity to “*re-engage Mr Cauchi in treatment and care in a pro-active manner*”.⁴⁰⁶ These comments were also made in relation to Dr Sarkar as noted above.⁴⁰⁷

- 2.424 Professor Nielssen opined as follows (although I note the evidence of Dr Parkar was that he did not speak to Dr Boros-Lavack):

*Dr Parkar spoke to Dr Boros-Lavack, and based on that information and her [sic] own assessment, did not recommend Mr Cauchi resume antipsychotic medication. The reasons could include that Mr Cauchi appeared well enough in the course of those interactions and was also clear in his wish not to resume medication. He would also have attempted to conceal signs of mental illness from Dr Parkar, as he sought her [sic] support for a clearance to hold a firearms permit, rather than for treatment of schizophrenia.*⁴⁰⁸

- 2.425 Counsel Assisting submitted with respect to Dr Parkar’s care and treatment of Mr Cauchi that (as for other practitioners) the real problem for Dr Parkar was the lack of information received from Dr Boros-Lavack as to the signs of deterioration in Mr Cauchi’s mental health from at least October 2019. Counsel Assisting noted that Dr Parkar gave evidence that if information regarding Mrs Cauchi’s concerns of deterioration had been provided, he “*probably would have*” called Mrs Cauchi to satisfy himself that he was not missing any essential information.⁴⁰⁹
- 2.426 Counsel Assisting also submitted that information relating to Mr Cauchi’s possible early warning signs of relapse would have been critical to Dr Parkar’s assessment of Mr Cauchi for the purposes of a Statement of Eligibility application (although the concessions made by Dr Parkar with respect to the medical certificate connected to a Statement of Eligibility application are dealt with elsewhere in these findings in Part 3). Counsel Assisting submitted this underscores the need for a comprehensive and readily accessible summary at the time a patient with treatment resistant schizophrenia is discharged from care.⁴¹⁰

⁴⁰⁴ Exhibit 1, Vol 22, Tab 808, Oxford Clinic medical records at p. 7; Exhibit 1, Vol 23, Tab 832, Weapons Act application for Statement of Eligibility to join a Pistol Shooting Club at p. 8.

⁴⁰⁵ Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [5.2].

⁴⁰⁶ Exhibit 1, Expert Volume, Tab 8, Expert Report of Professor Edward Heffernan at [7.2.3].

⁴⁰⁷ Exhibit 1, Expert Volume, Tab 16, Expert Report of Professor Anthony Harris at [5.2].

⁴⁰⁸ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [138].

⁴⁰⁹ Written submissions of Counsel Assisting at [437].

⁴¹⁰ Written submissions of Counsel Assisting at [439].

- 2.427 The submissions on behalf of Dr Parkar are adopted as accurate in Counsel Assisting's submissions.
- 2.428 I accept Counsel Assisting's above submissions with respect to Dr Parkar's care of Mr Cauchi. I note however that 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.
- 2.429 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.
- 2.430 This underscores the need for a comprehensive and readily accessible summary upon a patient's discharge.

Consultation with GP Dr Pietsch (November 2023)

- 2.431 On 13 November 2023, Mr Cauchi was seen by Dr Pietsch, a GP 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.
- 2.432 There is no evidence that Mr Cauchi saw any medical professional after this occasion (which was approximately five months prior to Mr Cauchi's death).
- 2.433 Dr Pietsch explained in evidence that a medical assessment for fitness to drive must be conducted in accordance with the standards within the "AustRoads Guidelines" (which are considered later in these findings).⁴¹¹
- 2.434 In the consultation notes taken by Dr Pietsch, he recorded:⁴¹²
- (a) Mr Cauchi's licence had an "M" (meaning "medical");
 - (b) *"[H]istory a little hazy – after some digging found he has a significant mental health history – HPP system – has been treated for schizophrenia on clozapine – but only as recently as 2012. Eventual transfer to Dr Boros-Lavack since then. ...";*
 - (c) A mental state examination was performed and Mr Cauchi had "unusual affect" and "poor eye contact", although otherwise had "no overt bizarre behaviour";
 - (d) Mr Cauchi denied being on medications recently;

⁴¹¹ Transcript, D13 (Pietsch): T1178.4-7 (15 May 2025). See also Exhibit 1, Vol 45, Tab 1603, Bundle of Fitness to Drive resources.

⁴¹² Exhibit 1, Vol 22, Tab 810, Northpoint Medical Centre medical records at pp. 2-3.

- (e) Dr Pietsch wrote: *“ideally need collateral”*. Dr Pietsch called Mrs Cauchi who confirmed Mr Cauchi’s history, that he had seen Dr Boros-Lavack until 2-3 years ago, and *“had been put on M class licence only when clozapine introduced due to drowsiness?”*;
- (f) Dr Pietsch recorded Mr Cauchi: *“has been weaned off antipsychotics with Dr [Boros-Lavack] but lost to follow up over past few years”*;
- (g) Dr Pietsch’s notes indicate he planned to clarify, with respect to driving rules, whether an “M” condition on the licence was still required; and
- (h) Dr Pietsch wrote a letter to Dr Boros-Lavack.

2.435 As Dr Pietsch explained further in his statement and oral evidence:⁴¹³

- (a) Mr Cauchi had an “M” category licence that was due to expire the following day. Dr Pietsch states: *“This category of licence is for persons with a medical condition that may impact fitness to drive. [Mr Cauchi] was seeking a medical certificate so that he could renew his licence”*.⁴¹⁴ The result of an “M” condition is that the person needs to carry a medical certificate whilst they are driving;⁴¹⁵
- (b) Mr Cauchi said he had some form of mental health history but was not forthcoming about details when questioned;⁴¹⁶
- (c) Dr Pietsch accessed the Health Practitioner Portal (**HPP**) which allowed him to review certain data in that system in relation to Mr Cauchi;⁴¹⁷
- (d) Dr Pietsch thought Mr Cauchi’s *“presentation was unusual”* (in that he was *“socially awkward”* and difficult to converse with in a flowing manner, which would not be unusual for a person with schizophrenia),⁴¹⁸ however *“there was no overt bizarre behaviour or tangential thinking”* and Mr Cauchi *“did not appear to be psychotic”*;⁴¹⁹
- (e) Dr Pietsch contacted Mrs Cauchi, with Mr Cauchi’s consent and in Mr Cauchi’s presence. Dr Pietsch states *“[s]he thought he may have been placed on a M licence due to drowsiness associated with clozapine”*,⁴²⁰ and that he would have asked Mrs Cauchi about whether Mr Cauchi had been well and at his baseline recently, and she did not express concerns;⁴²¹

⁴¹³ See Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch.

⁴¹⁴ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch at [2.7].

⁴¹⁵ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch at p. 7; Transcript, D13 (Pietsch): T1177.40-46 (15 May 2025).

⁴¹⁶ See also Transcript, D13 (Pietsch): T1183.22-29 (15 May 2025).

⁴¹⁷ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch at [2.9].

⁴¹⁸ Transcript, D13 (Pietsch): T1183.34-42 (15 May 2025).

⁴¹⁹ Transcript, D13 (Pietsch): T1183.34-42 (15 May 2025).

⁴²⁰ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch at [2.12].

⁴²¹ See also Transcript, D13 (Pietsch): T1186.18-23 (15 May 2025).

- (f) After speaking with Mrs Cauchi, Dr Pietsch completed a medical certificate and noted that Mr Cauchi should remain on an "M" licence. Dr Pietsch states that he *"decided to maintain the status quo in the absence of further information about why the M licence was required ..."*.⁴²²
- (g) Dr Pietsch agreed with the expert opinion of Professor Heffernan that, with the benefit of hindsight, this was a missed opportunity to make a more assertive recommendation about Mr Cauchi re-engaging with psychiatric care;⁴²³ and
- (h) Dr Pietsch gave evidence that it would be very difficult to have made an interstate referral to a NSW public local health service in the health district Mr Cauchi was going to be located in, especially given Mr Cauchi did not have a fixed address.⁴²⁴

- 2.436 The Medical Certificate for Motor Vehicle Driver contains a "tear-off" section that must be carried when driving. In that section, the review/expiry date recorded for Mr Cauchi was 13 November 2028 (that is, five years) and the details of the licence conditions/restrictions provide: *"Periodic [review]. Previous mental health treatment order"*.⁴²⁵
- 2.437 Dr Pietsch explained that he made the expiry date be the same as the expiry date of Mr Cauchi's driver licence, noting that the AustRoads document does not provide exact guidance as to the length of time for the review period (for certain medical conditions).⁴²⁶ Dr Pietsch agreed that for a person with a long-term mental health condition, it may be preferable to have shorter review periods.⁴²⁷ Dr Pietsch also gave oral evidence that generally, there is no good mechanism to ensure that a periodic review does occur and it is reliant on the patient, other than potentially using practice software to send an automated letter or text to the patient.⁴²⁸
- 2.438 On 13 November 2023, Dr Pietsch wrote to Dr Boros-Lavack seeking information regarding Mr Cauchi's mental health history. Dr Pietsch gave evidence that he wrote this letter directly after the consultation.⁴²⁹ In the letter, Dr Pietsch noted: *"Joel wasn't frankly psychotic at this point"; "[h]e has been off medication for a number of years now without readmission or major relapse" and "I could not find a reason why he requires an ongoing M on his licence to be honest"*.⁴³⁰
- 2.439 On 16 November 2023, the Mi-Mind Centre provided collateral information (being four letters) to Dr Pietsch in relation to Mr Cauchi.⁴³¹ The covering letter from Dr Boros-

⁴²² Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch at [2.13].

⁴²³ Transcript, D13 (Pietsch): T1192.22-33 (15 May 2025).

⁴²⁴ Transcript, D13 (Pietsch): T1193.28-38 (15 May 2025).

⁴²⁵ Exhibit 1, Vol 22, Tab 810, Northpoint Medical Records at pp. 8-9.

⁴²⁶ Transcript, D13 (Pietsch): T1188.36-39 (15 May 2025).

⁴²⁷ Transcript, D13 (Pietsch): T1189.3-5 (15 May 2025).

⁴²⁸ Transcript, D13 (Pietsch): T1180.32-37 (15 May 2025).

⁴²⁹ Transcript, D13 (Pietsch): T1189.7-10 (15 May 2025).

⁴³⁰ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch (GP) at [2.14]; Exhibit 1, Vol 22, Tab 810, Northpoint Medical Centre medical records at p. 17; See also Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 89-90.

⁴³¹ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at pp. 83-88.

Lavack dated 16 November 2023 provides “[t]hank you for your recent request for information relating to Joel, who I last consulted with in April 2015. I have attached 4 GP letters which I hope will address your questions” and does not refer to a telephone call with Dr Pietsch.

2.440 In her first statement prepared for the Inquest, Dr Boros-Lavack stated that Dr Pietsch was provided “*similar comprehensive collateral information*”. The letters provided to Dr Pietsch were:⁴³²

- (a) Letter from Dr Boros-Lavack to Dr Grundy dated 12 June 2019 (as set out above);
- (b) A letter from Dr Boros-Lavack to Dr Grundy dated 1 June 2017. This indicates that Mr Cauchi’s first episode schizophrenia had remained in full remission for 15 years on Clopine which had been gradually discontinued over five or so years without rebound or relapse;
- (c) The second opinion letter from Dr Stephens to Dr Boros-Lavack dated 14 July 2015; and
- (d) The letter from Dr Boros-Lavack to Dr Grundy dated 6 March 2012 (which includes the DSM-IV diagnosis).

2.441 Accordingly, Dr Pietsch was not provided the discharge letter from Dr Boros-Lavack to Dr Grundy dated 19 March 2020.

2.442 Dr Pietsch reviewed that information on 17 November 2023. Dr Pietsch states that based on the consultation with Mr Cauchi and the information received, he did not consider Mr Cauchi to be at risk to himself or others. Further, Dr Pietsch states he did not take any further action regarding Mr Cauchi’s “M” licence and did not consider any follow up action was required.⁴³³

2.443 Counsel Assisting submitted:

*Unbeknown to any medical practitioner who Mr Cauchi saw after he was discharged from Mi-Mind, or to Mr Cauchi’s family, Mr Cauchi’s mental state was perilous at this time and he was clearly extremely unwell, and a risk to others. For example, it is now known that on 16 November 2023, ... Mr Cauchi took a photo of a notebook entry with content regarding stabbing, dying, and departing a “store”; and ... During a phone call with Kennards Storage Camperdown, Mr Cauchi advised staff that his email address had changed to: “rambo...”*⁴³⁴

Standard of care provided by Dr Pietsch

2.444 Dr Wilson opined:

Given that Dr Pietsch did not change the status of the driver’s licence, assessed that there were no acute mental health issues and discussed Mr Cauchi with Mr Cauchi’s

⁴³² Exhibit 1, Vol 22, Tab 810, Northpoint Medical Centre medical records at pp. 12-15.

⁴³³ Exhibit 1, Vol 22, Tab 809, Statement of Dr John Pietsch (GP) at [3.3].

⁴³⁴ Written submissions of Counsel Assisting at [463].

*mother, it was not unreasonable to complete the licence application at the time of the consult...Dr Pietsch's management was adequate and appropriate.*⁴³⁵

- 2.445 Dr Kruys opined that the driver's licence assessment conducted by Dr Pietsch was "*adequate and appropriate*". Further, Dr Kruys opined that Dr Pietsch's approach to history-taking and fact-finding was comprehensive and he agreed with Dr Pietsch's recommendation to continue the "M" condition on the licence.⁴³⁶
- 2.446 Dr Kruys commented that he did not see evidence that periodic mental health reviews were organised, which would have been consistent with the recommended condition on Mr Cauchi's licence of "[p]eriodic review".⁴³⁷
- 2.447 Counsel Assisting submitted with respect to Dr Pietsch's care and treatment of Mr Cauchi that I would not be critical of Dr Pietsch and that "*his candid self-reflection is appreciated*".⁴³⁸
- 2.448 Counsel Assisting submitted that the problem for Dr Pietsch (as was the problem for Dr Ruge, Dr Sarkar and Dr Parkar) was that Dr Boros-Lavack did not record in a discharge summary the signs of deterioration in Mr Cauchi's mental health from at least October 2019 (as reported by Mrs Cauchi and apparent in Mr Cauchi's behaviour). I note in any event that the discharge letter from Dr Boros-Lavack to Dr Grundy dated 19 March 2020 was not provided to Dr Pietsch.
- 2.449 On behalf of Dr Pietsch, it was submitted that he only interacted with Mr Cauchi on one occasion, for the discrete purpose of renewal of a driver licence, and that notwithstanding the inherent limitations, Dr Pietsch "*appropriately (and commendably) accessed the HPP and obtained Mr Cauchi's consent to speak with his mother (in Mr Cauchi's presence) in order to obtain a better understanding of Mr Cauchi's medical history (and the reasons for his existing 'M' category licence)*".⁴³⁹ It was submitted on behalf of Dr Pietsch that he was then satisfied that it was appropriate to maintain the status quo with respect to the "M" classification, but nonetheless took a further step on 13 November 2023 of writing to Dr Boros-Lavack to seek information regarding Mr Cauchi's mental health history.
- 2.450 It was submitted on behalf of Dr Pietsch that there is no room for any criticism or adverse comment of any kind with respect to Dr Pietsch, "*whose conduct ought only be regarded as reasonable in every regard*".⁴⁴⁰

⁴³⁵ Exhibit 1, Expert Volume, Tab 4, Expert Report of Dr Hestor Wilson at pp. 20 - 21, lines 476-480.

⁴³⁶ Exhibit 1, Expert Volume, Tab 6, Expert Report of Dr Edwin Kruys at [81].

⁴³⁷ Exhibit 1, Expert Volume, Tab 6, Expert Report of Dr Edwin Kruys at [52].

⁴³⁸ Written submissions of Counsel Assisting at [461].

⁴³⁹ Written submissions on behalf of Dr Pietsch at [5].

⁴⁴⁰ Written submissions on behalf of Dr Pietsch at [8].

- 2.451 It was also submitted on behalf of Dr Pietsch that he “*demonstrated genuine and candid self-reflection (albeit with the benefit of hindsight and subsequently learning of the immeasurable gravity of the event that ultimately transpired)*”.⁴⁴¹
- 2.452 I accept the submissions of Counsel Assisting and 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.
- 2.453 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.

Whether there was a phone call between Dr Pietsch and Dr Boros-Lavack

- 2.454 Dr Boros-Lavack gave oral evidence that Dr Pietsch called her after his consultation with Mr Cauchi.⁴⁴²
- 2.455 Dr Pietsch gave evidence that he does not recall speaking to Dr Boros-Lavack and that whilst it is possible such a phone call occurred, if it had occurred as described by Dr Boros-Lavack, he would have made a note of that;⁴⁴³ that phone calls with psychiatrists are relatively rare; and that “*given I wrote a letter, that doesn’t make sense that I would have written a letter after just talking to her*”.⁴⁴⁴ This comment may suggest that Dr Pietsch’s understanding was that any purported call occurred on 13 November 2023 (that is, the date of the appointment and the date of his letter).
- 2.456 Counsel Assisting submitted that there is a call log within the brief of evidence from Dr Pietsch’s GP practice which appears to show an incoming call from the Mi-Mind Centre reception phone number on 16 November 2023 (at 3:06pm), however it is unclear who from Mi-Mind Centre called and who they spoke to.⁴⁴⁵
- 2.457 That call log from Dr Pietsch’s practice does not record any call between Mi-Mind Centre and Dr Pietsch’s practice on 13 November 2023.⁴⁴⁶
- 2.458 The Mi-Mind Centre records also include the following related information:⁴⁴⁷
- (a) On 15 November 2023 at 12:08pm, an “Admin” entry of Mrs Julie Fox contains an image of the letter from Dr Pietsch and states “*Added GP letter from elntray – forwarded to ABL to respond. Julie*”; and
 - (b) On 16 November 2023 at 2:49pm, a clinical entry (an image seemingly of the signed letter to Dr Pietsch) is attributed to Dr Boros-Lavack.

⁴⁴¹ Written submissions on behalf of Dr Pietsch at [9].

⁴⁴² Transcript, D11 (Boros-Lavack): T977.11-26 (13 May 2025).

⁴⁴³ Transcript, D13 (Pietsch): T1189.37-T1190.31 (15 May 2025).

⁴⁴⁴ Transcript, D13 (Pietsch): T1190.33-39 (15 May 2025).

⁴⁴⁵ Electronic Material, Item 67, Call log – North Point Medical Centre.

⁴⁴⁶ Electronic Material, Item 67, Call log – North Point Medical Centre.

⁴⁴⁷ Exhibit 1, Vol 20, Tab 793, Mi-Mind medical records at p. 17.

- 2.459 Counsel Assisting ultimately submitted that I would not accept that Dr Boros-Lavack called Dr Pietsch, and that “[p]erhaps she genuinely believes now that she did, but this appears to be a reconstruction”.⁴⁴⁸
- 2.460 Counsel Assisting submitted that there is no primary evidence of a call between Dr Pietsch's practice and the Mi-Mind Centre on 13 November 2023 (that is, the day of the appointment) and there is only primary evidence of a call on 16 November 2023 from Mi-Mind Centre to Dr Pietsch, and it is not clear that Dr Boros-Lavack made that call as opposed to someone else from the Mi-Mind Centre.
- 2.461 Counsel Assisting also submitted that Dr Boros-Lavack gave evidence multiple times that Dr Pietsch called her, and that does not align with the phone records. Further, Counsel Assisting submitted that Dr Pietsch gave persuasive oral evidence that it would not have made sense for him to write the letter to Dr Boros-Lavack on 13 November 2023 after having just spoken to her via phone.
- 2.462 Counsel for Dr Pietsch submitted:
- ... insofar as there is a factual contest about whether or not Dr Pietsch telephoned Dr Boros-Lavack after ... his consultation with Mr Cauchi, the available evidence (once again comprehensively summarized by Counsel Assisting at [454] to [457] of their submissions) and the apparent logic of events are overwhelmingly against such a proposition.*⁴⁴⁹
- 2.463 Counsel for the Good, Singleton and Young families submitted that, in a similar vein to her evidence regarding purported calls with Dr Grundy, Dr Boros-Lavack gave evidence that she had a phone call with Dr Pietsch which she did not document in her clinical file. The families submitted “*that Dr Boros-Lavack’s evidence regarding a telephone call to Dr Pietsch is another recent invention, made to avoid criticism of her conduct*”.⁴⁵⁰
- 2.464 The submissions on behalf of Dr Boros-Lavack included that the record of the phone call was produced to the Court after Dr Boros-Lavack first referred to the phone call with Dr Pietsch in her oral evidence, and that I would not accept the serious allegation made in submissions that Dr Boros-Lavack’s evidence as to a phone call with Dr Pietsch was a “*recent invention*”.⁴⁵¹
- 2.465 I accept Counsel Assisting’s submissions. 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

⁴⁴⁸ Transcript, Closing Submissions D1: T1918.9-15 (25 November 2025).

⁴⁴⁹ Written submissions on behalf of Dr John Pietsch at [10].

⁴⁵⁰ Written submissions on behalf of Good, Singleton and Young families at [4.46].

⁴⁵¹ Written submissions on behalf of Dr Boros-Lavack at [18.1]-[18.3].

to someone else from the Mi-Mind Centre practice). Neither Dr Boros-Lavack nor Dr Pietsch made a note of any call between them.

- 2.466 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)

- 2.467 Below is a summary of evidence in relation to Mr Cauchi's mental health from March 2020 to April 2024 (that is, after his discharge from the Mi-Mind Centre), from sources other than his interactions with medical professionals (and noting that interactions with QPS and NSWPF are set out elsewhere in these findings).

General evidence

- 2.468 After Mr Cauchi moved to Brisbane, Mr Cauchi Snr tried to remain in contact via phone and visited him in Kangaroo Point, however Mr Cauchi rarely answered his phone and they lost touch during the COVID lockdowns.⁴⁵² Mrs Cauchi states that whilst Mr Cauchi was in Kangaroo Point she did not visit him, largely due to COVID and also as she knew there was little she could do if he had deteriorated.⁴⁵³

- 2.469 Two of Mr Cauchi's flatmates in Brisbane, and a person from whom he rented a room, provided statements in relation to their observations of Mr Cauchi in the period from 2020 to 2022 as follows:

- (a) A housemate of Mr Cauchi's that lived with him in Carina until August 2020 gave evidence that "*it was obvious Joel couldn't look after himself*"; it appeared Mr Cauchi was not able to have a "*normal conversation*"; and that:

I remember whilst Joel was living with me, I could hear him making scream noises and, on an occasion, I heard banging noises coming from his room like he had hit something. I remember confronting him about it asking if he had hit the cupboard or tables and he would say no and look at me funny. His behaviour reminded me of like a twelve-year-old kid having a tantrum like he was losing his game.

That housemate states that whilst he considered Mr Cauchi to be "*a bit odd*", he considers Mr Cauchi's actions on 13 April 2024 were "*way out of character*" and not in his nature.

- (b) A person from whom Mr Cauchi rented a room at Kangaroo Point (until around March 2022) stated that he asked Mr Cauchi about his disability (which he believes Mr Cauchi mentioned to him). Mr Cauchi indicated via WhatsApp in

⁴⁵² Exhibit 1, Vol 15, Tab 773, Statement of Andrew Cauchi at [16], [18].

⁴⁵³ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [39].

August 2020 that: *"I was diagnosed with a mental illness 20 years ago and still see a doctor, but I have been fine for decades now. I don't have any symptoms that would affect my stay at your place. I have been good actually."* That individual did not recall experiencing issues with Mr Cauchi, other than him playing music too loudly (which he would turn down when asked) and one occasion when Mr Cauchi left a hot pan or similar on a wooden table.

On 17 March 2021, Mr Cauchi asked this person from whom he rented a room to be a reference for him to use guns at a gun club for sport. Mr Cauchi indicated he would email him a form, although did not do so, and they did not discuss it further.

The person from whom Mr Cauchi rented a room stated that he was shocked that Mr Cauchi was responsible for the events on 13 April 2024, as Mr Cauchi had appeared *"harmless"* although lonely.

- (c) A housemate of Mr Cauchi's at Kangaroo Point (from around September 2020 to March 2022) was advised, by the person from whom Mr Cauchi rented a room, that Mr Cauchi had mental health issues when Mr Cauchi was moving into the unit. This housemate gave evidence that Mr Cauchi would mostly keep to himself, and when Mr Cauchi did go out, he was well dressed and presented. Further, this housemate states:
- i. Mr Cauchi would play music loudly;
 - ii. *"Joel would walk around loudly when he was angry and shout and yell out loudly randomly. I could never really understand what he was yelling out as most of the time it would sound like gibberish";*
 - iii. On 3 May 2021, Mr Cauchi was yelling loudly and his behaviour seemed to be escalating, which concerned the housemate. He considered this may have been due to Mr Cauchi's mental health issues;
 - iv. On 27 May 2021, the housemate became aware police had attended the home in relation to Mr Cauchi yelling about a fridge tray (which he considered was common for Mr Cauchi);
 - v. *"In my opinion, I would say Joel was a shy, quiet type of guy, but his actions and behaviours would probably cause concern to other people who used to living with him. Throughout the time Joel lived with us I would see him at times walking aggressively thumping the floor, with mood swings and suddenly have a twitch where his body would just go into uncontrollable movements. Joels head and neck would turn and twist side to side and he would yell gibberish at the same time with signs of anger or irritation in his face. I would often see him do this. I just decided to stay away from Joel when this would happen just to be on the safe side";*

- vi. Mr Cauchi obsessed over washing sheets, towels and clothes and always excessively washed his hands, which the housemate considered seemed like a person with OCD; and
- vii. *"I would often have to teach Joel how to do basic things like how to flush the toilets and lock the doors to the shower or toilet as he did not seem to have the capacity to understand that he needs to do these things like a normal person would do. I would question his mindset and if he had the capacity to understand he needed to do these basic things. ..."*

This housemate states he was extremely shocked to learn of Mr Cauchi's actions on 13 April 2024, *"as he never shouted at us or [was] aggressive to us, I just knew he had something going on in his head."*

- 2.470 On 8 March 2022, Mr Cauchi moved from Brisbane back to the Cauchi family home in Toowoomba. A family friend that helped during the move located six or seven *"American SEAL knives"* as well as *"two big pigging knives with yellow handles in sheaths"*. That family friend recalls Mr Cauchi Snr saying words to the effect of, *"I'm worried my son is going to kill us in our sleep"*.
- 2.471 On 22 March 2022, Mr Cauchi searched the internet regarding an all-girls school in Toowoomba. On 27 July 2022, a Crime Stoppers report was made in relation to Mr Cauchi's communications with that school's staff and his attendance at the school, requesting to observe sporting events (this is discussed in further detail in Part 3).
- 2.472 The QPS attendance at Mr Cauchi's family home on 8 January 2023, in response to him reporting that Mr Cauchi Snr had taken his knives, is also addressed in Part 3 of these findings. Professor Large gave evidence that on 8 January 2023, he considered Mr Cauchi was psychotic.⁴⁵⁴
- 2.473 On 9 January 2023, Mr Cauchi purchased another KA-BAR USMC knife. Professor Nielssen opines that Mr Cauchi buying another knife shortly after the QPS incident of 8 January 2023 *"may have reflected the presence of a delusional belief that he needed that kind of knife to protect himself"*.⁴⁵⁵ Mr Cauchi Snr states that Mr Cauchi said to Mrs Cauchi words to the effect of, *"Mum, if I wanted to kill someone I could just go to the kitchen and get a knife"*.⁴⁵⁶
- 2.474 Mr Cauchi Snr also states that his son was *"obviously struggling"* when he moved back home and he kept to himself and would slap his own face and stamp his feet on the ground in the middle of the night.⁴⁵⁷ Mrs Cauchi states that at this time, her son *"just had an obsession with knives ..."*.⁴⁵⁸

⁴⁵⁴ Transcript, D16 (Large): T1462.8-49 (22 May 2025).

⁴⁵⁵ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [131].

⁴⁵⁶ Exhibit 1, Vol 15, Tab 773, Statement of Andrew Cauchi at [21].

⁴⁵⁷ Exhibit 1, Vol 15, Tab 773, Statement of Andrew Cauchi at [21]-[23].

⁴⁵⁸ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [44].

- 2.475 In April 2023, Mr Cauchi indicated that he wanted to anonymously donate sperm.⁴⁵⁹ In around June 2023, Mr Cauchi set up profiles on various escort sites.
- 2.476 On 21 July 2023, NSWPF officers interacted with Mr Cauchi whilst he was homeless in Sydney and conducted a search for knives, with none located (although he had cutlery).⁴⁶⁰ This is addressed elsewhere in these findings.
- 2.477 On 22 September 2023, Mr Cauchi had dinner with three of Mr Cauchi Snr's siblings whilst he was visiting Melbourne. They generally indicated there was nothing remarkable about Mr Cauchi's behaviour on that date.
- 2.478 Mr Cauchi's parents last saw him in person in November 2023, when he left Toowoomba for the Gold Coast and then Sydney. After this, Mrs Cauchi communicated with Mr Cauchi mostly via text and email.⁴⁶¹
- 2.479 On 22 December 2023, Mr Cauchi left Queensland for the last time and moved to Sydney. Whilst living in Sydney, Mr Cauchi was homeless, and most observations of Mr Cauchi from this point onwards were limited to people who interacted with him and did not know him well.
- 2.480 On 5 April 2024, Mr Cauchi asked his mother to redirect all correspondence to his "rambo..." email address.⁴⁶² On that date, he sent 72 message enquiries regarding rooms for lease advertised on Facebook.⁴⁶³
- 2.481 On 9 April 2024, Mr Cauchi asked Mrs Cauchi via text message for a copy of his previous car's registration certificate.⁴⁶⁴ This was Mrs Cauchi's last contact with Mr Cauchi.
- 2.482 On 11 April 2024, Mr Cauchi returned his car number plates to a Service NSW/Transport for NSW location.⁴⁶⁵

Examination of Mr Cauchi's phone and notes

- 2.483 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, including the following:⁴⁶⁶

⁴⁵⁹ Exhibit 1, Vol 22, Tab 797, Queensland Fertility Group medical records at pp. 4-6.

⁴⁶⁰ Exhibit 1, Vol 23, Tab 870, Statement of Constable Cooper McLaren at [22]; Exhibit 1, Vol 22, Tab 871, BWV of Constable Cooper McLaren.

⁴⁶¹ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [51].

⁴⁶² Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [58].

⁴⁶³ Exhibit 1, Vol 26, Tab 960, Statement of Detective Senior Constable Danielle Kirchen at [14].

⁴⁶⁴ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [59].

⁴⁶⁵ Exhibit 1, Vol 27, Tab 964, Photos of interest extracted from Cellebrite download of Joel Cauchi's mobile phone at pp. 25-26.

⁴⁶⁶ Exhibit 1, Vol 26, Tab 960, Statement of Detective Senior Constable Danielle Kirchen at [11]-[12], [31]-[38], [45]; Exhibit 1, Vol 27, Tab 980; Exhibit 1, Vol 26, Tab 958, Statement of Sergeant Nathan Cosstick at [11] and p. 9; Exhibit 1, Vol 27, Tab 982, Searched items extracted from Cellebrite download of Joel Cauchi's mobile phone; Exhibit 1, Vol 27, Tab 964, Photos of interest extracted from Cellebrite download of Joel Cauchi's mobile phone at p. 6; Exhibit 1, Vol 27, Tab 968, Google Calendar entries extracted from Cellebrite download of Joel Cauchi's mobile phone.

- (a) On 16 December 2022, Mr Cauchi saved a bookmark regarding mass attacks in public spaces.
- (b) On 24 October 2023, Mr Cauchi searched the internet in relation to serial killers, self-inflicted death in prison, a firearm, and an all-girls school (as referred to above).
- (c) In November 2023, Mr Cauchi searched the internet in relation to the most recent mass stabbing in Australia, assault rifles, and dying.
- (d) A photograph taken on 16 November 2023 on Mr Cauchi's phone depicts a notebook with handwriting that refers to stabbing and departing a "store" (as referred to above).
- (e) On 25 January 2024, Mr Cauchi recorded notes titled "To do" including "Make sure I do schoolgirls first in strike , see how get lots of. 14year olds together in 1st attack run sim" and "Call knife sharpener and confirm it doesn't need sharpening for mall use." Further information regarding Mr Cauchi's interest in knives is contained in Part 4 of these findings.
- (f) In February 2024, Mr Cauchi recorded or updated a note that included: "Check out malls and also where to run. Begin to assert aus army military assets in region".
- (g) In January 2024 and February 2024, he recorded various notes indicating planning of a "strike" or "attack".
- (h) In February and April 2024, Mr Cauchi searched the internet in relation to mass murderers or serial killers.
- (i) On or around 11 April 2024, Mr Cauchi viewed/cached Twitter posts regarding killing and the Beau Lamarre-Condon case.
- (j) On 13 April 2024 (the day of the incident), Mr Cauchi searched the internet for "Beat (police)" and from around 8:47am searched for information regarding the Columbine perpetrators.
- (k) There was also generally a significant focus on pornography and sex workers.

Evidence of Mr Cauchi's drug use prior to 13 April 2024

2.484 Further, the records extracted from Mr Cauchi's mobile phone indicate that he sought to obtain drugs between December 2023 and April 2024. This was generally cannabis but also included methylamphetamine, ecstasy, cocaine and psychedelic mushrooms on some occasions.

- 2.485 Mr Cauchi interacted with Facebook groups that appear to relate to recreational drug use.⁴⁶⁷
- 2.486 From January to 8 April 2024, Mr Cauchi's Facebook messages indicate he was attempting to source illicit drugs, including cocaine and marijuana. Most of his messages did not receive a response. He sent a message on 22 January 2024 indicating he had obtained "*blow*".
- 2.487 DSC Danielle Kirchen reviewed chat logs extracted from Mr Cauchi's phone and stated that Mr Cauchi appeared to be an inexperienced drug user.⁴⁶⁸ This is corroborated by his internet searches.⁴⁶⁹
- 2.488 In addition, on 5 January 2024 Mr Cauchi went surfing with someone he met through a Facebook advertisement, who states that Mr Cauchi said he was into acid and LSD and also that he had schizophrenia and sometimes went into psychosis and was unmedicated.
- 2.489 Evidence as to drug use in the period around 13 April 2024 is addressed in the next section.
- 2.490 Counsel Assisting submitted:

*The evidence establishes Mr Cauchi was actively seeking and using drugs. His Kennards Storage locker in Waterloo contained cannabis, which was also identified in his system postmortem. The expert evidence discloses Mr Cauchi was using cannabis recreationally prior to 13 April 2024. There is further evidence of various attempts by Mr Cauchi to purchase drugs over social media, as well as accounts of his drug use ...*⁴⁷⁰

⁴⁶⁷ Exhibit 1, Vol 27, Tab 966, Screenshots extracted from Cellebrite download of Joel Cauchi's mobile phone at p. 5.

⁴⁶⁸ Exhibit 1, Vol 26, Tab 960, Statement of Detective Senior Constable Danielle Kirchen at [23].

⁴⁶⁹ Exhibit 1, Vol 27, Tab 982, Searched items extracted from Cellebrite download at pp. 79, 85, 94, 107, 121, 126.

⁴⁷⁰ Written submissions of Counsel Assisting at [860].

G. Mr Cauchi's mental state on 13 April 2024

- 2.491 Mr Cauchi's parents have indicated that his actions on 13 April 2024 were not consistent with his usual character. Mrs Cauchi gave evidence that "*he wouldn't have done what he did in Bondi Junction if he had been in his right mind*" and that if Mr Cauchi had been re-commenced on medication after 13 April 2024, "*he would not have coped at all with what he had done*".⁴⁷¹
- 2.492 Other observations of Mr Cauchi's general behaviour and personality, from mental health practitioners and people who knew Mr Cauchi, have been set out above.

Mr Cauchi's mental state on 13 April 2024

- 2.493 Professor Nielssen opined that on 13 April 2024, Mr Cauchi was undoubtedly experiencing an acute psychotic relapse of his chronic condition, and there were "*plenty of signs of it ...*".⁴⁷² The remainder of the expert psychiatrist panel agreed with his conclusion that Mr Cauchi was psychotic.⁴⁷³ Counsel Assisting submitted that Professor Large ultimately agreed with the conclusion reached by his colleagues.
- 2.494 Counsel Assisting submitted that there is no doubt that on 13 April 2024 Mr Cauchi was suffering from an acute exacerbation of his chronic mental illness, chronic schizophrenia. Counsel Assisting submitted that each of the expert psychiatrists agreed Mr Cauchi had chronic schizophrenia.
- 2.495 Counsel Assisting further submitted that Mr Cauchi was experiencing an acute episode of psychosis on 13 April 2024 after a period of decline and "*his behaviour was utterly inconsistent with the person who he was when he was well*".⁴⁷⁴ Counsel Assisting submitted that it is uncontroversial that Mr Cauchi's mental health had declined significantly and he was no longer appearing well or able to mask his mental health conditions.
- 2.496 Counsel Assisting referred to Professor Nielssen's expert evidence that:
- The pattern of symptoms is typically similar to the symptoms experienced previous acute episodes of mental illness, and hence it is likely that Mr Cauchi was experiencing hallucinations of voices and associated persecutory beliefs.*⁴⁷⁵
- 2.497 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.

⁴⁷¹ Exhibit 1, Vol 15, Tab 772, Statement of Michele Cauchi at [62].

⁴⁷² Transcript, D16 (Nielssen): T1463.24-25 (22 May 2025).

⁴⁷³ Transcript, D16 (Nielssen/Harris): T1461.43-46 (22 May 2025).

⁴⁷⁴ Transcript, Closing Submissions D1: T1905.24-25 (25 November 2025).

⁴⁷⁵ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [131].

Mr Cauchi's post-mortem toxicology results

- 2.498 Toxicological testing of Mr Cauchi's blood post-mortem returned a positive result for cannabis.⁴⁷⁶
- 2.499 As noted elsewhere, cannabis was also located in Mr Cauchi's storage locker after his death.

Expert evidence of toxicologist, Professor Jones

- 2.500 The expert report of toxicologist, Professor Alison Jones obtained by those assisting in this Inquest matter, suggests that Mr Cauchi had been using cannabis ("*significant personal use*") "*within days preceding his death*".⁴⁷⁷ Professor Jones subsequently clarified that "*significant*" (in the context of personal or recreational cannabis use) refers to "*clinically significant*" (that is, a level "*likely to have had clinical effects on Mr Cauchi, such as on behaviours*").⁴⁷⁸
- 2.501 The supplementary expert report of Professor Jones suggests Mr Cauchi was likely using cannabis on a recreational basis before his death.⁴⁷⁹
- 2.502 Professor Jones also opined:

... Because of the known long persistence of psychological effects of Δ9THC [Delta-9-tetrahydrocannabinol], Mr Cauchi was likely acting under some influence of cannabis in the hours immediately preceding his death. The degree of these psychological effects may be attenuated by tolerance to the chronic use of the drug, and exacerbated by some underlying psychiatric conditions.

The adverse effects of recreational cannabis also use [sic] include tachycardia, hypertension, sedation, cognitive impairment, altered time perceptions and hallucinations (Baselt). Whilst THCA was detected in Mr Cauchi's blood on the 16th April 2024, it is also likely that his cannabis use impacted his mental health in the days preceding his death.

*The advice of an expert psychiatrist would also be recommended on the likely behavioural impacts of cannabis use on Mr Cauchi.*⁴⁸⁰

Expert evidence of psychiatrists

- 2.503 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.

⁴⁷⁶ Exhibit 1, Vol 15, Tab 766, Autopsy Report (Joel Cauchi) at p. 8.

⁴⁷⁷ Exhibit 1, Expert Volume, Tab 1, Expert Report of Professor Alison Jones at p. 3.

⁴⁷⁸ Exhibit 1, Expert Volume, Tab 2, Supplementary Report of Professor Alison Jones at p. 1.

⁴⁷⁹ Exhibit 1, Expert Volume, Tab 2, Supplementary Report of Professor Alison Jones at p. 1.

⁴⁸⁰ Exhibit 1, Expert Volume, Tab 1, Expert Report of Professor Alison Jones at p. 4.

Submissions

- 2.504 As noted earlier, Counsel Assisting submitted that Mr Cauchi's previous mental health history:

*... coincided with a time when he was smoking marijuana. While there is a known link between marijuana use and psychosis, it is also the case that persons suffering from a mental illness may self-medicate with cannabis, which ultimately worsens their psychiatric condition. That appears to be the case for Joel Cauchi.*⁴⁸¹

- 2.505 With respect to the period prior to 13 April 2024, Counsel Assisting submitted that:

*It is likely Mr Cauchi's cannabis use exacerbated his mental health conditions. During the expert conclave, Professors Large and Nielssen gave evidence about the impact of cannabis on mental health conditions, particularly schizophrenia.*⁴⁸²

- 2.506 With respect to the events on 13 April 2024, Counsel Assisting submitted:

*It is likely that the consumption of cannabis – especially when he was not medicated with any antipsychotic medication – contributed to the severe psychotic state he was in on 13 April 2024. However, it should be noted that the early warning signs of a relapse were present from at least October 2019, and became clearer by February 2020, at a time when it appears, on the available evidence, that Mr Cauchi was not using cannabis. It is likely that his further decline into mental illness over the intervening period, clouded his judgement and contributed to his isolation, and his ultimate decision to use cannabis.*⁴⁸³

- 2.507 Counsel Assisting submitted, more generally, that the expert panel explained that if a person who is predisposed to mental illness is exposed to cannabis, that drug is very detrimental to their mental health. Professor Large explained this issue may not be as well understood in the community as it should be and people prone to mental illness may be drawn to cannabis to attempt to stop what they are experiencing (such as voices in their head), which becomes a vicious cycle.⁴⁸⁴

Findings

- 2.508 Based on all of the expert evidence before me (which I accept), I accept Counsel Assisting's submissions on this topic.
- 2.509 As noted above, 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.

⁴⁸¹ Written submissions of Counsel Assisting at [512].

⁴⁸² Written submissions of Counsel Assisting at [861].

⁴⁸³ Written submissions of Counsel Assisting at [518].

⁴⁸⁴ Transcript, Closing Submissions D1: T1895.15-22 (25 November 2025).

Any motivations of Mr Cauchi on 13 April 2024

- 2.510 Professor Nordentoft was the only expert psychiatrist that specifically opined that it is likely that Mr Cauchi targeted “*young girls and women*”, with young women being his primary target, on 13 April 2024. Professor Nordentoft also opined:

*One can only speculate about the content of his delusion. There could be a delusional explanation, an inner private logic, for his actions, but there is no material that can inform us of this matter.*⁴⁸⁵

- 2.511 Professors Nielssen, Heffernan and Harris indicated they were not able to come to a clear conclusion regarding Mr Cauchi's motivations or particular targeting of any individuals or groups, and Professor Heffernan commented: “*I believe his motive was derived from his psychotic thinking and therefore it is not possible to identify a rational motive*”.⁴⁸⁶

- 2.512 Counsel Assisting submitted as follows:

There was no logical motivation for the attacks on 13 April 2024 and they can only be explained in the context of the severe psychotic state described above. The Court would accept the evidence of Professor Nordentoft that “One can only speculate about the content of his delusion. There could be a delusional explanation, an inner private logic, for his actions, but there is no material that can inform us of this matter.”

Professor Nordentoft opined that “it is likely” that women were the target of the attacks. That opinion is supported by the fact that by the time he committed these acts, Mr Cauchi had demonstrated some disturbing attitudes towards women (see for example, the content of the google calendar entries which blur his attitudes about women and girls with his plans for a strike or attack). Further, it is inescapable that the first victim was a young woman and the majority of the victims killed were women. However, there is other evidence that mitigates against the conclusion that he was targeting women: first, three men were stabbed in the attacks on 13 April, one of whom (Mr Tahir) died. Second, the disparity in female victims may reflect the fact that a greater number of women were shopping on a Saturday afternoon in [Westfield Bondi Junction].

*Finally, while there is ample evidence that Mr Cauchi had dark and violent thoughts in the months leading up to the attacks, and that his behaviour on 13 April was depraved, it was entirely out of character to the man he was when he was well. As explained by Mr Cauchi's former treating doctors; the nursing staff at the Mi-Mind Centre; his parents, friends and former flatmates, he was not a man who exhibited violent tendencies (save for limited exceptions, including prior to his first diagnosis in 2001) and he was, by nature, gentle. It is tragic that he became so mentally unwell that he was driven by psychosis to commit the atrocities of 13 April 2024, that led to the loss of so many innocent lives, and the injury (psychological and physical) of many more.*⁴⁸⁷

⁴⁸⁵ Exhibit 1, Expert Volume, Tab 14, Expert Report of Professor Merete Nordentoft at [76].

⁴⁸⁶ Exhibit 1, Expert Vol, Tab 8, Expert Report of Professor Edward Heffernan at [9.7].

⁴⁸⁷ Written submissions of Counsel Assisting at [519]-[521].

- 2.513 The submissions on behalf of Dr Boros-Lavack with respect to Mr Cauchi's motivations on 13 April 2024 are dealt with below.
- 2.514 As noted above, Professor Nordentoft was the only expert psychiatrist that specifically opined that Mr Cauchi targeted young girls and women on 13 April 2024.
- 2.515 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.

Dr Boros-Lavack's evidence regarding 13 April 2024

- 2.516 Dr Boros-Lavack was asked in her oral evidence about the events of 13 April 2024.
- 2.517 On 13 May 2025, Dr Boros-Lavack gave evidence that she did not believe that Mr Cauchi was experiencing psychosis on 13 April 2024. Dr Boros-Lavack said she disagreed with the expert psychiatrists who opined Mr Cauchi was experiencing psychosis linked to his severe treatment resistant schizophrenia.⁴⁸⁸ When asked whether she believed Mr Cauchi was suffering from psychosis on 13 April 2024 (noting she had not read all of the brief material that the experts had access to), Dr Boros-Lavack gave evidence as follows:

*I have to answer you based on my knowledge that in 2001, 2002 when he was psychotic, the main, main domain of his problem was disorganisation. I honestly believe that his - that is my opinion, that was nothing to do with psychosis. He couldn't have organised himself to do what he did. I think it might have been, might have been due to his, his frustration, sexual frustration, pornography and hatred towards women. That is my opinion.*⁴⁸⁹

- 2.518 Dr Boros-Lavack did not agree with the proposition that she refused to accept Mr Cauchi was psychotic on 13 April 2024 because she did not want to accept her failings in his care. She responded: *"I did not fail in my care of Joel, and I refuse. I, I have no error on my behalf. That is my answer"*.⁴⁹⁰
- 2.519 However, during her evidence the following day on 14 May 2025, 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).⁴⁹¹

Submissions

- 2.520 It was submitted on behalf of the Good, Singleton and Young families that whilst Dr Boros-Lavack withdrew her evidence regarding 13 April 2024 and acknowledged that

⁴⁸⁸ Transcript, D11 (Boros-Lavack): T958.44-48 (13 May 2025).

⁴⁸⁹ Transcript, D11 (Boros-Lavack): T958.30-35 (13 May 2025).

⁴⁹⁰ Transcript, D11 (Boros-Lavack): T983.44-45 (13 May 2025).

⁴⁹¹ Transcript, D11 (Boros-Lavack): T957-T958, T983 (13 May 2025); Transcript, D12 (Boros-Lavack): T1004-T1006, T1049-T1050 (14 May 2025).

she had engaged in “*conjecture*”, that withdrawal was not given voluntarily; only occurred during cross-examination by their counsel after being pressed; Dr Boros-Lavack did not explicitly withdraw the evidence initially and attempted to support her position; and the fact that Dr Boros-Lavack gave the evidence at all demonstrates her attempts to distance Mr Cauchi’s acts from her treatment decisions.

- 2.521 The Good, Singleton and Young families submitted that Dr Boros-Lavack’s “*conjecture*” that Mr Cauchi committed these terrible crimes because of sexual frustration and hatred towards women was regrettable and further traumatised the families. The families submitted that Dr Boros-Lavack’s answer was also contrary to all expert evidence, quite outrageous and offensive, and self-serving.
- 2.522 It was submitted on behalf of Dr Boros-Lavack that the submission that she was deliberately disingenuous, in order to justify her evidence regarding Mr Cauchi’s condition on 13 April 2024, “*misstates the initial evidence from [Dr Boros-Lavack] on [13 May 2025] as to her understanding of [Joel Cauchi]’s mental state on 13 April 2024. She never offered an opinion that [Joel Cauchi] was “not unwell when he acted so violently on 13 April 2024”.*”⁴⁹²
- 2.523 It was also submitted on behalf of Dr Boros-Lavack that “*it’s quite likely that the resumption of drug use had a very major part to play both contemporaneously and causally connected to*” the events on 13 April 2024.
- 2.524 Counsel Assisting submitted that they do not understand the first of those submissions, as it is contrary to Dr Boros-Lavack’s oral evidence and the clear understanding of those in Court for that evidence (including families) that Dr Boros-Lavack was “*trying to suggest that Mr Cauchi was not mentally unwell [on 13 April 2024] and was in fact motivated by malice*”.
- 2.525 Counsel Assisting submitted that Dr Boros-Lavack’s answer to the question regarding Mr Cauchi’s mental state on 13 April 2024 was “*genuinely shocking*” and whilst it is to her credit that she resiled from the answer, I would accept the Families’ submissions that the evidence was only withdrawn after Dr Boros-Lavack was pressed.
- 2.526 In oral submissions, Counsel for Dr Boros-Lavack submitted that Dr Boros-Lavack initially gave evidence that she thought Mr Cauchi was not psychotic on 13 April 2024 because Mr Cauchi’s conduct was too well organised and speculated that factors involved might have included his attitude towards women. It was submitted on behalf of Dr Boros-Lavack that it was deeply regrettable that the families felt further traumatised by those remarks, however in one sense the question should never have been asked; the question was objected to by counsel for Dr Boros-Lavack on the basis that Dr Boros-Lavack was not qualified as an expert to answer; and it was “*grossly unfair*” that Dr Boros-Lavack was forced to answer the question.

⁴⁹² Written submissions on behalf of Dr Boros-Lavack at [5.12].

- 2.527 Further, it was submitted on behalf of Dr Boros-Lavack that she “*hadn’t had the benefit of reading*” any of the material the experts had digested, which was of critical importance to the question; that her evidence on the point did not rise “*beyond a possibility*” that Mr Cauchi may not have been psychotic at the time; and that her evidence is “*not a view that’s distant entirely from that of the eminent expert Dr Nordentoft*”.
- 2.528 In reply, Counsel Assisting submitted that there was no unfairness in the questioning and that Dr Boros-Lavack did have the opportunity to review all the information that the experts reviewed, noting the entire brief of evidence was provided to Dr Boros-Lavack through her representatives.
- 2.529 Counsel Assisting submitted that it is not correct to say that Professor Nordentoft at any time opined that Mr Cauchi was not psychotic, and all of the expert psychiatrists were very clear that Mr Cauchi experienced a psychotic episode on 13 April 2024 after a significant decline.
- 2.530 In addition, Counsel Assisting submitted that on 13 May 2025, she asked Dr Boros-Lavack about this topic after Dr Boros-Lavack, unprompted by any question of Counsel Assisting, said: “*It wouldn’t have changed the outcome and in hindsight, it wasn’t necessary-- ... --the medication--*”. Counsel Assisting submitted that Dr Boros-Lavack was determined to give that evidence unprompted.

Findings

- 2.531 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.
- 2.532 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.
- 2.533 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.
- 2.534 This was a serious flaw in her judgement.
- 2.535 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.

- 2.536 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

- 2.537 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.
- 2.538 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.
- 2.539 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.
- 2.540 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.
- 2.541 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.
- 2.542 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.
- 2.543 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.

- 2.544 I also accept that Dr Boros-Lavack did fail to make appropriate concessions in her oral evidence.
- 2.545 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.
- 2.546 The concessions made on behalf of Dr Boros-Lavack via written submissions following the hearing are addressed elsewhere in these findings.

H. Relevant policies, guidelines and procedures

2.547 This section sets out key policies, guidelines and procedures relevant to Mr Cauchi's care and treatment.

Schizophrenia and clozapine guidelines (psychiatrists)

2.548 Professor Nielssen commented in his expert report as follows:

*The high probability of relapse in a person who has continued to experience acute symptoms after some years of treatment with very high doses of clozapine, and the very acute episodes of psychosis experienced by a number of patients who have stopped clozapine, resulting to my knowledge in at least three other homicides, suggests that great caution should be exercised in ceasing that medication.*⁴⁹³

2.549 For individuals with treatment resistant schizophrenia, clozapine (with brand names Clozaril or Clopine) is the medication indicated.⁴⁹⁴ Professor Heffernan, Professor Nielssen, Professor Harris, and Professor Nordentoft agreed that clozapine is generally considered a lifelong medication for treatment resistant schizophrenia and if it is ceased, the risk of relapse and readmission are significantly increased.⁴⁹⁵

2.550 Professor Large gave evidence that many patients do cease taking clozapine (often ceasing it themselves), which is often associated with relapse, and also that the most severely unwell treatment resistant patients are not on clozapine (and instead are on an intramuscular injection of another antipsychotic medication).⁴⁹⁶ Professor Large also gave evidence that "clozapine is the single antipsychotic that is most known to reduce violence".⁴⁹⁷

2.551 The RANZCP published "*Clinical practice guidelines for management of schizophrenia and related disorders*" in 2016. Those guidelines are no longer in effect.⁴⁹⁸

2.552 Professor Harris explained that each Australian state also has guidelines regarding particular issues in relation to clozapine, such as initiation or maintenance, and those are generally quite similar.⁴⁹⁹

2.553 Counsel Assisting proposes the following recommendations to the RANZCP (Proposed Recommendations 1.A, 1.B and 1.D):

⁴⁹³ Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [32], [155].

⁴⁹⁴ Transcript, D16 (Nielssen/Heffernan/Harris/Nordentoft/Large): T1389.50-T1390.7 (22 May 2025).

⁴⁹⁵ Transcript, D16 (Nielssen/Heffernan/Harris/Nordentoft/Large): T1389.9-38 (22 May 2025).

⁴⁹⁶ Transcript, D16 (Large): T1391.17-27 (22 May 2025).

⁴⁹⁷ Transcript, D16 (Large): T1466.11-19 (22 May 2025).

⁴⁹⁸ Exhibit 1, Vol 49, Tab 1610, Cherrie Galletly et al, 'Royal Australian and New Zealand College of Psychiatrists clinical guidelines for the management of schizophrenia and related disorders' (2016) 50(5) *Australian and New Zealand Journal of Psychiatry*.

⁴⁹⁹ Transcript, D16 (Harris): T1378.35-39 (22 May 2025).

Proposed Recommendation 1.A: addressed to the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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*”.

Prompt attention should be given to an amendment of the Guidelines on the management of schizophrenia and related disorders, which should include the following matters (as appropriately formulated by those undertaking the review):

- (a) An outline of the types of psychotic disorders described in the DSM-5-TR, including schizophrenia; schizophreniform disorder; schizoaffective disorder; brief psychotic disorder and delusional disorder;
- (b) A description of the disorder known as Schizophrenia;
- (c) a definition of Treatment Resistant Schizophrenia;
- (d) that evidence demonstrates a significant risk of relapse for patients with schizophrenia who cease medication;
- (e) that patients with chronic forms of schizophrenia who have relapsed after ceasing medication should be advised to stay on medication indefinitely, given the high risk of relapse;
- (f) that if a patient with treatment-resistant schizophrenia elects to cease their medication, they should be monitored indefinitely if possible, and in accordance with the separate practice guideline on “deprescribing” antipsychotic medication (see draft recommendation 1.B).

Proposed Recommendation 1.B: addressed to the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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.

Such a Guideline should include:

- (i) Advice to the patient on the risk of relapse and the longitudinal clinical adversity associated with relapse (that is, not only is the patient likely to relapse, but each time they do, the illness has greater long term impacts on their outcomes);
- (ii) Advice to the patient on how to recognise early warning signs of relapse;
- (iii) A contingency plan articulating appropriate actions to be taken and pathways to care, should a person or their support network find evidence of early warning signs;
- (iv) Advice on who to contact in the event of signs of relapse;
- (v) Advice on how to educate family and friends to recognise the signs of relapse;
- (vi) The requirement for a written discharge letter on handover of a patient with

treatment resistant schizophrenia, with the following minimum requirements:

- (a) A history of the patient's illness and treatment;
- (b) Overview of symptoms in last 6 months of treatment;
- (c) Findings from the most recent mental state examination;
- (d) Probability of relapse;
- (e) Advice as to early warning signs of relapse;
- (f) Any relevant support persons who are available to assist the patient and contact details;
- (g) Advice that regular review by a psychiatrist should be included in any management plan for the patient.

Proposed Recommendation 1.D: to the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

That the RANZCP collaborate with the Royal Australian and New Zealand 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

2.554 The RANZCP has indicated that the RANZCP no longer funds and develops clinical practice guidelines on an independent and self-funded basis, however the RANZCP will explore alternative resources with respect to the *Clinical Practice Guideline for management of schizophrenia and related disorders*, given the importance of those issues. With respect to other proposed recommendations relevant to the RANZCP, the RANZCP has indicated that it will further consider their feasibility.

2.555 I have determined to make these recommendations proposed by Counsel Assisting.

RECOMMENDATIONS

Recommendation 2: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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*".

Prompt attention should be given to an amendment of the Guidelines on the management of schizophrenia and related disorders, which should include the following matters (as appropriately formulated by those undertaking the review):

- (a) An outline of the types of psychotic disorders described in the DSM-5-TR, including schizophrenia; schizophreniform disorder;

schizoaffective disorder; brief psychotic disorder and delusional disorder;

- (b) A description of the disorder known as schizophrenia;
- (c) A definition of "Treatment Resistant Schizophrenia";
- (d) That evidence demonstrates a significant risk of relapse for patients with schizophrenia who cease medication;
- (e) That patients with chronic forms of schizophrenia who have relapsed after ceasing medication should be advised to stay on medication indefinitely, given the high risk of relapse; and
- (f) That if a patient with treatment resistant schizophrenia elects to cease their medication, they should be monitored indefinitely if possible, and in accordance with the separate practice guideline on "deprescribing" antipsychotic medication.

Recommendation 3: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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.

Such a Guideline should include:

- (a) Advice to the patient on the risk of relapse and the longitudinal clinical adversity associated with relapse (that is, not only is the patient likely to relapse, but each time they do, the illness has greater long term impacts on their outcomes);
- (b) Advice to the patient on how to recognise early warning signs of relapse;
- (c) A contingency plan articulating appropriate actions to be taken and pathways to care, should a person or their support network find evidence of early warning signs;
- (d) Advice on who to contact in the event of signs of relapse;

- (e) Advice on how to educate family and friends to recognise the signs of relapse;
- (f) The requirement for a written discharge letter on handover of a patient with treatment resistant schizophrenia, with the following minimum requirements:
 - i. A history of the patient's illness and treatment;
 - ii. Overview of symptoms in last six months of treatment;
 - iii. Findings from the most recent mental state examination;
 - iv. Probability of relapse;
 - v. Advice as to early warning signs of relapse;
 - vi. Any relevant support persons who are available to assist the patient and contact details; and
- (g) Advice that regular review by a psychiatrist should be included in any management plan for the patient.

Recommendation 4: To the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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.

Applications for a Statement of Eligibility for firearms (psychiatrists)

2.556 Dr Parker's consideration of Mr Cauchi's Statement of Eligibility application request is addressed in Part 3. However, I will address here the guidelines in this area and Counsel Assisting's proposed recommendation.

- 2.557 At the time of Mr Cauchi's consultations with Dr Parkar and Dr Sarkar in late 2020 to early 2021, the Queensland Health "Health and Weapons" information booklet was in effect (and the letter from QPS to Dr Parkar contained a hyperlink to a website through which that booklet could be accessed).
- 2.558 That booklet essentially relates to a health professional's decision-making when they may have concerns about a patient's access to a weapon and capacity to have a weapons licence. However, the flowchart within the booklet notes: *"This is a different process from a request from a patient or police for a report regarding a person's fitness to have a weapons licence"*.⁵⁰⁰
- 2.559 In September 2023, subsequent to the appointments with Dr Sarkar and Dr Parkar, the RANZCP issued its Professional Practice Guidelines 23 titled "Firearm risk assessments", which is intended to provide best-practice guidance to psychiatrists in assessing risk posed by a person's access to firearms. Those guidelines include the following:⁵⁰¹
- (a) *"Some aspects of firearm risk assessments may fall outside the scope of what medical opinions a psychiatrist can provide such as if the applicant is a 'fit and proper person'. Psychiatrists should limit their recommendations to areas where their medical training and expertise allow them to comment on the nature and treatment of identified mental health conditions ...";* and
 - (b) Risk assessments are best provided in circumstances where the psychiatrist knows the applicant.
- 2.560 A more general issue was raised during the Inquest with respect to people with schizophrenia having access to firearms. In his expert report, Professor Nielssen opines that people diagnosed with a major mental illness, including schizophrenia, should be excluded from having access to firearms.⁵⁰² The Australian-based experts generally indicated a person with treatment resistant schizophrenia should not have access to firearms.⁵⁰³
- 2.561 Counsel Assisting submitted:

Although this Court would be mindful not to interfere unnecessarily with rights of persons with a mental illness, Counsel Assisting suggests that the position advocated for by Professor Nielssen - that people diagnosed with a major mental illness, including schizophrenia, should be excluded from having access to firearms - warrants closer consideration and analysis, and ultimately a review of the RANZCP 'Professional Practice Guideline 23 – Firearm risk assessments' (2023) ... Ultimately, Mr Cauchi did not use a firearm to inflict harm on others on 13 April 2024, but the Court would not

⁵⁰⁰ Exhibit 1, Vol 23, Tab 835A, Queensland Government, Health and Weapons Information Booklet. See hyperlink in letter at Exhibit 1, Vol 23, Tab 835 Weapons Licensing Letter to Dr Sagir Parkar, which links to a website page that states "Posted 16/08/2018".

⁵⁰¹ Exhibit 1, Vol 59, Tab 1618A, Professional Practice Guideline 23: Firearm Risk Assessments (Royal Australian and New Zealand College of Psychiatrists) (v 1.0) at [5.1]-[5.3].

⁵⁰² Exhibit 1, Expert Volume, Tab 10, Expert Report of Professor Olav Nielssen at [156]-[157].

⁵⁰³ Transcript, D16 (Large/Harris/Heffernan/Nielssen): T1467.17-T1468.36 (22 May 2025). See also D16 (Nielssen/Large/Heffernan): T1500.34-T1502.18 (22 May 2025).

*want to miss an opportunity to refer this important issue for the consideration of the Royal Australian and New Zealand College of Psychiatrists, and it is the subject of a recommendation.*⁵⁰⁴

2.562 Counsel Assisting proposed the following recommendation (Proposed Recommendation 1.C):

Proposed Recommendation 1.C: to the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Commissioner of Police (NSW) and Commissioner of Police (QLD)

That the Commissioner of Police (NSW) and Commissioner of Police (QLD) 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:

- (1) the extent to which RANZCP 'Professional Practice Guideline 23 – Firearms Risk Assessment' (2023) provide appropriate guidance for psychiatrists and firearms licensing authorities;
- (2) 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
- (3) the views expressed in the evidence of the expert psychiatric panel obtained during the inquest hearing.

2.563 The following response was provided on behalf of the NSWPF (as well as noting that this process is being considered in another ongoing inquest):

The Firearms licensing regime in NSW was not explored in evidence in this inquest. Nevertheless, the NSWPF would consider participating in such a working group if recommended.

*For the information of the State Coroner: from 2021 to 2024, the NSW Firearms Registry worked closely with medical experts—including the NSW Health Secretary and the NSW Chief Psychiatrist—to develop the current Health Risk Assessment (HRA) process. This collaboration ensured the guidelines reflect best practices in mental health and public safety. The current HRA process was launched December 2024. The Firearms Registry has commenced a 6-month post implementation review of the HRA process to assess the effectiveness of the existing guidelines. This review includes a survey of health practitioners and Registry staff.*⁵⁰⁵

2.564 I have determined to make the recommendation as proposed by Counsel Assisting.

⁵⁰⁴ Written Submissions of Counsel Assisting at [569].

⁵⁰⁵ NSWPF, NSW and NSW Health position on joint recommendations at p. 1.

RECOMMENDATION**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**

That the Commissioner of the NSW Police Force and the 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 the 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.

Transfer of care (GPs)

2.565 Counsel Assisting submitted:

Evidence suggests that it is very rare for a General Practitioner to be responsible for monitoring a patient with treatment resistant schizophrenia who has ceased clozapine. There is no relevant guideline as to the role of a General Practitioner if such a person is discharged into their care. It appears that there may be a role for further education of General Practitioners as to the risks associated with treatment resistant schizophrenia and the importance of obtaining collateral history from a treating psychiatrist, when a patient is discharged into their care. Counsel Assisting has drafted a relevant recommendation directed to the Royal Australian College of General Practitioners ...⁵⁰⁶

2.566 Counsel Assisting proposed the following recommendations to the RACGP (Proposed Recommendation 2):

⁵⁰⁶ Written submissions of Counsel Assisting at [572].

Proposed Recommendation 2: to the Royal Australian College of General Practitioners (RACGP)

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).

The Guideline should include:

General Recognition that:

- (1) General practitioners have a key role in supporting patients with schizophrenia.
- (2) General practitioners have a role in the early detection of prodromal symptoms, monitoring and preventing risks, including relapses, and providing high-quality primary and secondary prevention and treatment of common physical problems. However, this must be done in conjunction with the patient's specialist mental health service/consultant psychiatrist who have an important role assisting general practitioners, patients and carers to understand the risks and presentation of relapse for each patient.
- (3) Effective care requires a thorough understanding of local specialist services, cardiometabolic and other effects of pharmacotherapies, familiarity with psychosocial interventions and proactive multidisciplinary chronic disease management. This must be led by the patient's specialist mental health service/consultant psychiatrist who commit to informing the patient, carers and the patient's general practitioner to assist them to provide care in a collaborative framework effectively.
- (4) The General practitioner should ensure that they liaise with specialist mental health teams/consultant psychiatrists to obtain advice with respect to the matters outlined below, and to ensure that advice is passed on to the patient and carers. Such advice should cover:
 - (a) Advice on the risk of relapse if not medicated;
 - (b) Advice on how to recognise early warning signs of relapse;
 - (c) Who to contact in the event of signs of relapse;

Regarding Treatment Resistant Schizophrenia

- (1) Treatment resistant schizophrenia is uncommon, and general practitioners should not be expected to have thorough knowledge of this condition. Specialist mental health services/consultant psychiatrists must provide the patient, carers and the patient's general practitioner with the following:
 - (a) A definition of treatment resistant schizophrenia;
 - (b) Advice as to the circumstances in which a general practitioner can prescribe clozapine, noting that options and requirements may be

different in each state. This must include ongoing support from the patient's mental health service/consultant psychiatrist;

- (c) A clear understanding that a psychiatrist should be involved in the ongoing management of patients with chronic schizophrenia, including treatment resistant schizophrenia;
- (d) Advice that it is preferable for persons with treatment resistant schizophrenia to remain on medication;
- (e) An indication regarding the risk of relapse for patients with treatment resistant schizophrenia, who cease medication (for example, expressed as an "extremely high risk" or by way of percentage) and associated risks with regard to harm to self and others;
- (f) Advice about risks with regard to driving and access to/use of heavy equipment/machinery and weapons.

Minimum standards for a general practitioner on initial intake of a patient with treatment resistant or chronic schizophrenia

- (1) Once ongoing shared care of a patient with chronic schizophrenia (including treatment resistant schizophrenia) has been actively accepted by a general practitioner, the specialist mental health team/consultant psychiatrist must provide the patient, carers and the patient's general practitioner with the following:
 - (a) all relevant records from the public/private sector carer involved (including all recent discharge summaries and specialist outpatient letters);
 - (b) information to assist with ongoing assessment of the current risk of relapse and other risks for the patient;
 - (c) the likely signs/symptoms of relapse;
 - (d) the early warning signs/symptoms of relapse;
- (2) These aspects of care are a shared responsibility between specialist mental health services and general practitioners and require appropriate and timely clinical handover/communication.
- (3) The specialist mental health team/consultant psychiatrist has an important role in ensuring that they review the person at regular intervals appropriate for each patient in collaboration with the patient's general practitioner

Minimum clinical handover standards for a General Practitioner when the care of a patient with treatment resistant or chronic schizophrenia is transferred to another provider.

- (1) On transfer of a patient with treatment resistant or chronic schizophrenia to

another general practitioner, the current treatment team (Specialist mental health services/consultant psychiatrists/general practitioner) have a responsibility to:

- (a) explain to the patient, carers and the patient's new general practitioner the need for ongoing medical care and regular review by a general practitioner and psychiatrist; and
- (b) Prepare a comprehensive clinical handover letter, outlining:
 - I. the patient's current mental health status;
 - II. the risk of relapse and any other risks (eg self-harm, suicide, homicide, access to weapons, driving, ability to adhere to medications) at the time of discharge;
 - III. the early warning signs and symptoms of relapse;
- (c) Provide the patient with a copy of the letter;
- (d) Provide the patient, and (where possible) the patient's family/friends, with the contact details of other support services and the options for psychiatric care.

2.567 The RACGP has indicated that it would be happy to collaborate with the RANZCP on developing shared care guidelines and that strengthening care coordination and shared care models will improve patient outcomes. The RACGP has expressed that funding mechanisms should better support care coordination (noting for instance that GPs communicating with specialists outside of a patient consultation cannot obtain a rebate unless an MBS case conferencing item can be utilised).

2.568 I have determined to make this recommendation to the RACGP as proposed by Counsel Assisting.

RECOMMENDATION

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

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).

The Guideline should include:

General Recognition that:

- (a) General practitioners have a key role in supporting patients with schizophrenia.

- (b) General practitioners have a role in the early detection of prodromal symptoms, monitoring and preventing risks, including relapses, and providing high-quality primary and secondary prevention and treatment of common physical problems. However, this must be done in conjunction with the patient's specialist mental health service/consultant psychiatrist, who have an important role assisting general practitioners, patients and carers to understand the risks and presentation of relapse for each patient.
- (c) Effective care requires a thorough understanding of local specialist services, cardiometabolic and other effects of pharmacotherapies, familiarity with psychosocial interventions and proactive multidisciplinary chronic disease management. This must be led by the patient's specialist mental health service/consultant psychiatrist who commit to informing the patient, carers and the patient's general practitioner to assist them to provide care in a collaborative framework effectively.
- (d) The general practitioner should ensure that they liaise with specialist mental health teams/consultant psychiatrists to obtain advice with respect to the matters outlined below, and to ensure that advice is passed on to the patient and carers. Such advice should cover:
 - i. Advice on the risk of relapse if not medicated;
 - ii. Advice on how to recognise early warning signs of relapse; and
 - iii. Who to contact in the event of signs of relapse.

Regarding Treatment Resistant Schizophrenia

- (a) Treatment resistant schizophrenia is uncommon, and general practitioners should not be expected to have thorough knowledge of this condition. Specialist mental health services/consultant psychiatrists must provide the patient, carers and the patient's general practitioner with the following:
 - i. A definition of treatment resistant schizophrenia;
 - ii. Advice as to the circumstances in which a general practitioner can prescribe clozapine, noting that options and requirements may be different in each state. This must include ongoing support from the patient's mental health service/consultant psychiatrist;

- iii. A clear understanding that a psychiatrist should be involved in the ongoing management of patients with chronic schizophrenia, including treatment resistant schizophrenia;
- iv. Advice that it is preferable for persons with treatment resistant schizophrenia to remain on medication;
- v. An indication regarding the risk of relapse for patients with treatment resistant schizophrenia, who cease medication (for example, expressed as an “extremely high risk” or by way of percentage) and associated risks with regard to harm to self and others; and
- vi. Advice about risks with regard to driving and access to/use of heavy equipment/machinery and weapons.

Minimum standards for a general practitioner on initial intake of a patient with treatment resistant or chronic schizophrenia

- (a) Once ongoing shared care of a patient with chronic schizophrenia (including treatment resistant schizophrenia) has been actively accepted by a general practitioner, the specialist mental health team/consultant psychiatrist must provide the patient, carers and the patient's general practitioner with the following:
 - i. All relevant records from the public/private sector carer involved (including all recent discharge summaries and specialist outpatient letters);
 - ii. Information to assist with ongoing assessment of the current risk of relapse and other risks for the patient;
 - iii. The likely signs/symptoms of relapse; and
 - iv. The early warning signs/symptoms of relapse.
- (b) These aspects of care are a shared responsibility between specialist mental health services and general practitioners and require appropriate and timely clinical handover/communication.
- (c) The specialist mental health team/consultant psychiatrist has an important role in ensuring that they review the person at regular intervals appropriate for each patient in collaboration with the patient's general practitioner.

Minimum clinical handover standards for a general practitioner when the care of a patient with treatment resistant or chronic schizophrenia is transferred to another provider

On transfer of a patient with treatment resistant or chronic schizophrenia to another general practitioner, the current treatment team (specialist mental health services/consultant psychiatrists/general practitioner) have a responsibility to:

- (a) Explain to the patient, carers and the patient's new general practitioner the need for ongoing medical care and regular review by a general practitioner and psychiatrist;
- (b) Prepare a comprehensive clinical handover letter, outlining:
 - i. The patient's current mental health status;
 - ii. The risk of relapse and any other risks (for example, self-harm, suicide, homicide, access to weapons, driving, ability to adhere to medications) at the time of discharge;
 - iii. The early warning signs and symptoms of relapse;
- (c) Provide the patient with a copy of the letter; and
- (d) Provide the patient, and (where possible) the patient's family/friends, with the contact details of other support services and the options for psychiatric care.

Driver licence and “M” condition (GPs)

- 2.569 As at November 2023, when Dr Pietsch saw Mr Cauchi regarding renewal of his Queensland driver licence, the Austroads and National Transport Commission “Assessing fitness to drive for commercial and private vehicle drivers - Medical standards for licensing and clinical management guidelines” (2022 edition) were in effect.
- 2.570 Those standards include that: “[c]are should be taken when health professionals are dealing with drivers who are not regular patients”; “[t]he frequency of formal review regarding licence status is sometimes specified in this publication but often is left to the judgement of the health professional”; Section 7.1.1 sets out possible effects of schizophrenia on driving; and Section 7.3 considers when a conditional licence may be issued for a person with a psychiatric condition (such as schizophrenia).⁵⁰⁷

⁵⁰⁷ Exhibit 1, Vol 46, Tab 1603, Bundle of Fitness to Drive Resources at pp. 16, 22-23, 28.

- 2.571 Noting the standards currently in place, Counsel Assisting do not propose any recommendations on this topic. I accept that no recommendation is necessary or desirable.

Telehealth appointments

- 2.572 On 13 March 2020, COVID-related temporary Medicare Benefits Schedule (**MBS**) telehealth items were introduced in Australia and related regulations took effect. Relevant information was updated on “MBS Online” on 16 March 2020. As a result, Medicare benefits could be claimed in accordance with certain item numbers for telehealth appointments with a psychiatrist, if particular eligibility criteria were met.⁵⁰⁸
- 2.573 It is not apparent from the available evidence whether, and if so when, Mr Cauchi may have become eligible for telehealth appointments with Dr Boros-Lavack at around the time of his discharge or subsequently (given the evolving COVID situation from March 2020 onwards).
- 2.574 The Court has not heard further evidence about this issue and Counsel Assisting do not propose any related recommendations. I accept that no recommendation is necessary or desirable.

⁵⁰⁸ Exhibit 1, Vol 49, Tab 1609A, Statement of Louise Riley (Assistant Secretary, MBS Policy & Reviews Branch).

I. Mental health context in NSW and Queensland

- 2.575 The evidence in this Inquest in relation to Mr Cauchi's mental illness, social isolation, and homelessness gave rise to consideration of certain broader issues relating to mental health treatment and services, including supported accommodation options, for people living in both NSW and Queensland. This section addresses that broader mental health context.

Impact of de-institutionalisation

- 2.576 In Australia, the process of "de-institutionalisation" commenced in the 1960s. De-institutionalisation refers to the shift in mental health policy and service provision from "asylums" to less custodial and segregated approaches in which services are delivered in community settings.⁵⁰⁹
- 2.577 De-institutionalisation has been the focus of numerous inquiries into Australia's mental health system, including:
- (a) Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (1983) (the **Richmond Report**):⁵¹⁰ This report recommended that services primarily be delivered in integrated community-based networks, backed up by specialist hospital or other services as required, and emphasised the need for funding of community-based services.
 - (b) Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) (the **Burdekin Report**):⁵¹¹ This report found (amongst other things) that mental health services in the community remained seriously underfunded and increased funding and resources were urgently required and that supported accommodation needed to be established in all major metropolitan and regional centres (including crisis, medium-term and long-term accommodation).
 - (c) Productivity Commission Inquiry Report - Mental Health (2020) (the **Productivity Commission Report**):⁵¹² This report concluded that Australia's mental health system is not comprehensive and fails to provide sufficient treatment and support, and it recommended (amongst other things) that governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness.

⁵⁰⁹ Exhibit 1, Electronic Material, Item 70, The Report of the National Inquiry into the Human Rights of People with Mental Illness (1983) (**Burdekin Report**) at p. 136.

⁵¹⁰ Exhibit 1, Electronic Material, Item 69, Department of Health, Division of Planning and Research, 'Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled' (**Richmond Report**).

⁵¹¹ Exhibit 1, Electronic Material, Item 70, Burdekin Report.

⁵¹² Exhibit 1, Electronic Material, Item 71, Productivity Commission, 'Productivity Commission Inquiry Report – Mental Health' (**Productivity Commission Report**).

- 2.578 Professor Heffernan commented with respect to deinstitutionalisation that *“the funding for community services never really followed to match that movement and that shift”*.⁵¹³
- 2.579 Professor Heffernan also opined that the key issues for enhancing mental health care in Australia were identified by the Productivity Commission and relate to *“an underfunded public mental health system with a lack of community resourcing for accommodation, support, and care for people with chronic and severe mental illness”*.⁵¹⁴ Professor Heffernan identified the (required) areas for improvement as being:⁵¹⁵
- (a) Increased support for mental health care and crisis care in the community.
 - (b) Increased supported accommodation.
 - (c) Greater use of non-government and peer-led services through enhanced coordination and collaboration.
 - (d) Increased capacity in the private mental health sector.
 - (e) Enhanced capability of the primary care setting to undertake the assessment and management of people with severe mental illness through ensuring remuneration is commensurate with the time and complexity of consultations and enhanced support through increased access to mental health care training.⁵¹⁶
- 2.580 Counsel Assisting submitted that the above issues have been recognised by reports over a number of decades and inform an understanding of the *“pressures on the mental health system that failed Mr Cauchi”*; however, other than increased supported accommodation, these issues are beyond the scope of this Inquest as they have no obvious direct relationship to Mr Cauchi's death.⁵¹⁷ I accept that submission.

Supported housing

- 2.581 Counsel Assisting submitted that the expert psychiatrists highlighted the urgent need for short and long-term accommodation options for persons suffering from mental illness.⁵¹⁸
- 2.582 Professor Nielssen gave evidence that:

A major gap in the mental health services available in New South Wales is supported accommodation for people with severe forms of mental illness, mainly schizophrenia, who require basic support and supervision of adherence to medication to remain well. A significant proportion of hospital inpatients occupy those places because there is no suitable accommodation where people with severe mental illness can receive

⁵¹³ Transcript, D16 (Heffernan): T1464.18 – 25 (22 May 2025).

⁵¹⁴ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [12.1]. See also, Exhibit 1, Electronic Material, Item 71, Productivity Commission Report.

⁵¹⁵ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [12.1].

⁵¹⁶ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [12.1].

⁵¹⁷ Written submissions of Counsel Assisting at [2853].

⁵¹⁸ Written Submissions of Counsel Assisting at [2390].

*medication supervision, which causes bed block and results in patients who might benefit from treatment not being admitted, and effectively raises the threshold for involuntary care.*⁵¹⁹

2.583 Two of the expert psychiatrists in this Inquest gave evidence regarding the supported accommodation initiatives they are involved in, namely: Professor Nielssen (as the founder of Habilis housing in NSW) and Professor Harris (a Director of Mind Australia, with involvement regarding Haven housing in Victoria and other states).

2.584 As a brief overview of those supported housing initiatives:

- (a) **Haven** provides integrated social housing and support for people impacted by significant mental health and wellbeing challenges. Mind Australia provides 24/7 support for Haven's residents including for psychosocial and wellbeing support, improvement of mental and physical health, support with activities of daily living, and community connection. An evaluation of the first six Haven residences by La Trobe University found its residents experienced a number of benefits.

Haven has 12 residences in Victoria (comprising 188 apartments), with 13 residences (comprising 178 apartments) under construction in Victoria and South Australia. At this stage, a further two residences may be opened in NSW.⁵²⁰

- (b) **Habilis** provides indefinite supported accommodation and care for people with disabling forms of mental illness who would otherwise be homeless. To become a Habilis resident, a person must be willing to continue medication and abstain from substances. Habilis focuses on schizophrenia specifically and incorporates medical care into its model (which is different to Haven). Residents at Habilis can access services such as supervision of medication adherence and access to a weekly clinic with a visiting psychiatrist and mental health nurse.

The first Habilis housing opened in August 2024 in Summer Hill in Sydney and it is intended that further clusters of units will be built.⁵²¹

2.585 Professor Nielssen estimated that the cost of a person being housed and treated under the Habilis model is a tenth (10%) of the cost of alternative beds such as in hospitals or correctional centres.⁵²²

⁵¹⁹ Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [148].

⁵²⁰ Exhibit 1, Expert Volume, Tab 16, Report of Professor Anthony Harris at [9.1].

⁵²¹ Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [150]-[151]; Transcript, D16 (Nielssen): T1381.4-10, T1470.12-33 (22 May 2025).

⁵²² Transcript, D16 (Nielssen): T1470.35-44 (22 May 2025).

Submissions and proposed recommendation

2.586 Counsel Assisting proposed that I make a recommendation in relation to accommodation for people experiencing mental health issues, including having regard to Professor Nielssen's evidence as to a lack of short-term shelter accommodation in which medical care is provided and the success of, and obvious need for, longer-term accommodation such as that offered by Habilis and Haven.⁵²³

2.587 Further, Counsel Assisting submitted (with respect to a previous version of the proposed recommendations):

*The Court was grateful for the contribution of leading experts in the area of short and long-term psychiatric care, each of whom supported the reforms suggested. While the cost of mapping and implementing these recommendations is significant, they are ultimately extremely cost effective, given the potential to reduce crime, homelessness and social disorder, and the likelihood that it can avoid the type of tragedy experienced at [WBJ].*⁵²⁴

2.588 Counsel Assisting proposed the following recommendation (Proposed Recommendation 20):

Proposed Recommendation 20: To the Minister for Housing, Minister for Homelessness, Minister for Mental Health

That the Minister:

1) model the need for short term accommodation in the greater Sydney area for those experiencing mental health challenges and homelessness, and then establish and support those services.

2) support the establishment and ongoing evaluation of long term accommodation for those experiencing mental health challenges and homelessness, with onsite or easily accessible long term mental health care, based on the models delivered by Habilis (NSW) and Haven (Victoria).

2.589 It was submitted on behalf of NSW Health that it appears unnecessary for a recommendation to refer specifically to the models delivered by Habilis and Haven.⁵²⁵ I consider it is useful to refer to Habilis and Haven, given the evidence provided in the Inquest related specifically to these models and the efficacy of these models.

2.590 I make the following recommendation:

⁵²³ Written submissions of Counsel Assisting at [2954]-[2956]. See also, Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [149].

⁵²⁴ Written submissions of Counsel Assisting at [2957].

⁵²⁵ Written submissions on behalf of NSW Health and NSW Ambulance at [31].

RECOMMENDATION**Recommendation 7: To the NSW Government**

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).

Co-responder models

2.591 A co-responder model involves pairing police officers (or Ambulance officers) with persons who have mental health expertise (such as a mental health nurse) to facilitate a joint response to incidents that may have a mental health component. Co-responder models have been implemented in parts of NSW and Queensland.

2.592 Counsel Assisting submitted that:

The issue of a co-responder model arises in this Inquest, not because there was an opportunity for a co-response in NSW, but because, on review of the interaction between Joel Cauchi and QPS on 8 January 2023, had the co-responder model been available at that time (either the ambulance led model or the police led model, which are discussed further below), it would have been an ideal opportunity for that service to follow up Mr Cauchi and his family after the initial interaction with QPS. Unfortunately, no co-responder model was available in the Darling Downs District at that time, although they commenced later that year. The Court will therefore be interested to understand the availability of that model of care in NSW, particularly given the increasing burden on NSWPF to manage mental health episodes in the community.⁵²⁶

2.593 The current NSW and Queensland co-responder models are set out below, as well as the UK model ("Right Care, Right Person") that NSW is currently considering adopting.

Background to co-responder models

2.594 The Productivity Commission recommended as a priority that:

State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental

⁵²⁶ Written submissions of Counsel Assisting at [2894].

*health professionals should be embedded in police communication centres and police, mental health professionals, and/or ambulance services should be able to co-respond to mental health related incidents.*⁵²⁷

2.595 The Victorian Royal Commission into Mental Health published its report in 2021 and found that the current mental health system was not equipped to handle mental health emergencies; that police were often the first responders to mental health crises; that police-led responses can lead to poor outcomes for police and people in crises; and that their involvement can increase trauma and stigma.⁵²⁸ The Victorian Royal Commission made recommendations to the Victorian Government, including the following:

1. *ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.*
2. *support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that wherever possible and safe*
 - a. *Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and*
 - b. *responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).*
3. *ensure that mental health clinical assistance is available to ambulance and police via:*
 - a. *24-hours-a-day telehealth consultation systems for officers responding to mental health crises;*
 - b. *in-person co-responders in high-volume areas and time periods; and,*
 - c. *diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.*⁵²⁹

2.596 The NSWPF conducted an internal review (published in April 2024) into its response to mental health incidents in the community (**NSWPF review**). That NSWPF review found as follows:⁵³⁰

The prevalence of mental ill-health continues to increase within the NSW community and the demands on health services and community supports are stretched. This demand has seen an increased dependence on police as the call of both first and last resort and an over reliance on police as the primary responders to emotional distress and mental health crises.

⁵²⁷ Exhibit 1, Electronic Material, Item 71, Productivity Commission Report at p. 1012.

⁵²⁸ Transcript, D6 (Quinlan): T425.6 - 13 (6 May 2025).

⁵²⁹ Victorian Royal Commission into Mental Health 2021, available at: <https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>.

⁵³⁰ Exhibit 1, Vol 49, Tab 1615, Summary Internal Review of the NSW Police Force response to mental health incidents in the community (April 2024) at p. 2.

The key recommendation of this review is that NSWPF work with NSW Health to explore models for responding to mental health incidents in NSW consistent with the principles of the 'Right Care, Right Person' model. This will require further consultation with stakeholders including NSW Health and Ambulance NSW, as well as consumers, peers, carers, and non-government organisations involved in mental health service provision.

*The 'Right Care, Right Person' model is centred on a trauma informed response to people suffering emotional distress and mental health crises. It ensures that the agency who can help the most is the agency to respond, and allows police to reinvest in focusing on core policing functions.*⁵³¹

- 2.597 Further, in May 2023 the Law Enforcement Conduct Commission (**LECC**) released a report into NSWPF critical incidents and found that between 2017 and 2022, 43% involved an interaction with a person in a mental health crisis. The report supported increased training for NSWPF officers on responding to persons in a mental health crisis and an expansion of NSW's PACER co-response model, outlined further below.⁵³²
- 2.598 This Inquest heard evidence from Inspector Bernard Quinlan (Manager of the Vulnerable Persons Group within QPS) (**Insp Quinlan**). Insp Quinlan identified that a lack of mental health support and services (in the wake of de-institutionalisation) was a reason for increased demand on police services.⁵³³ Insp Quinlan accepted that the QPS were still often frontline in dealing with mental health emergencies, and that this is likely to remain a core part of police duties.⁵³⁴ Counsel Assisting submitted that this is particularly true in circumstances where there is a lack of alternative services for people with mental illness and police are available to respond 24 hours, seven days a week.⁵³⁵
- 2.599 Professor Heffernan commented: "... we expect a lot from our police. And I think there is an opportunity to think about how does the mental health system work to support police and by corollary individuals in mental health crisis in the community in real time?"⁵³⁶

NSW co-responder model (PACER)

- 2.600 The current NSW co-responder model, PACER (Police, Ambulance, Clinician, Early, Response) commenced in 2018. It involves the stationing of a NSW Health mental health clinician in a police station in primarily metropolitan areas.⁵³⁷ PACER is resourced, managed, and funded by NSW Health through budget supplementation to the Local Health Districts (**LHDs**).⁵³⁸

⁵³¹ Exhibit 1, Vol 49, Tab 1615, Summary Internal Review of the NSW Police Force response to mental health incidents in the community (April 2024) at p. 2.

⁵³² Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [34]-[35].

⁵³³ Transcript D6 (Quinlan): T418:14-28 (6 May 2025).

⁵³⁴ Transcript D6 (Quinlan): T425.6-31 (6 May 2025).

⁵³⁵ Written submissions of Counsel Assisting at [2867].

⁵³⁶ Transcript D16 (Heffernan): T1464.30-33 (22 May 2025).

⁵³⁷ Written submissions of Counsel Assisting at [2873].

⁵³⁸ Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [20]; Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [25].

2.601 Dr Brendan Flynn (Executive Director, Mental Health Branch, NSW Ministry of Health) described PACER as having the following objectives:

- a. to provide an immediate, specialised, and trauma-informed mental health response for people experiencing a mental health crisis in the community who encounter NSW Police or NSW Ambulance;*
- b. to reduce Emergency Department (ED) presentations by providing de-escalation, alternate and less restrictive/coercive pathways to care; and*
- c. to achieve a more efficient use of emergency services resources by enhancing integrated, cross agency approaches to those in urgent need of emergency mental health care.*⁵³⁹

2.602 Police are able to request that PACER clinicians (who are experienced senior mental health clinicians) assist when responding to mental health-related incidents (although not high-risk incidents) with police officers, conduct mental health assessments of persons who may suffer from mental illness, and provide advice and support to officers responding to mental health jobs.⁵⁴⁰

2.603 When responding, PACER clinicians can provide:⁵⁴¹

- (a) Clinical assessment of the person's mental health status and needs;
- (b) Advice on mental health referral options;
- (c) Brief therapeutic intervention;
- (d) De-escalation support and strategies;
- (e) Referral pathways to community and inpatient care;
- (f) Advice on appropriate transport options; and
- (g) Formulation of interventions and strategies for consumers with complex needs who access emergency services.⁵⁴²

2.604 The exchange of health information between NSWPF and health staff is provided for via a Memorandum of Understanding entered into by NSW Health and the NSWPF in 2018. A new Memorandum of Understanding was being negotiated between NSW Health, NSWPF and NSW Ambulance which was anticipated to be finalised in 2025.⁵⁴³ Per the current Memorandum of Understanding, PACER clinicians and police are able to share information regarding the individual in crisis to provide a trauma-informed health response.

⁵³⁹ Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [13].

⁵⁴⁰ Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [16]; Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [15] – [16], [18].

⁵⁴¹ Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [19].

⁵⁴² Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [19].

⁵⁴³ Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [15].

- 2.605 In 2021, an evaluation of the PACER program was undertaken and published by Emerson Health for NSW Health. The key findings of that evaluation included.⁵⁴⁴
- (a) PACER delivers more timely access to mental health care;
 - (b) PACER reduces pressure on EDs and emergency services by decreasing the use of coercive care and involuntary admissions, with reports of up to 80% of consumers being diverted away from EDs by PACER;
 - (c) Strong support for the PACER program from consumers, carers, and stakeholders, and from NSW Health and NSWPF;
 - (d) Significantly improved mental health literacy within police; and
 - (e) A key challenge was the variability between sites, in the absence of a state-wide PACER model of care.
- 2.606 NSWPF has not conducted a formal evaluation of PACER. However, Superintendent Kirsty Hales (Commander of the Mental Health Command, Capability Performance and Youth Command, NSWPF) (**Supt Hales**) gave evidence that from her informal observations, NSWPF officer responses to PACER have been positive.⁵⁴⁵ Insp Scott described that in her experience, PACER is an “amazing” resource.⁵⁴⁶
- 2.607 One limitation of PACER is that it is not available 24 hours per day. Dr Flynn explained that the PACER budget is fully allocated and further expansion is subject to government funding. Dr Flynn also gave evidence that: *“The future of PACER and other co-responder models is currently under consideration by NSW Health and NSW Police as both agencies are working together to formulate options for government to consider”*.⁵⁴⁷
- 2.608 Another limitation of PACER is that PACER clinicians are restricted as to what health information they can access and they cannot access records from within the private system. Currently, there is also not a consistent electronic medical record available across all LHDs.⁵⁴⁸
- 2.609 Relatedly, the “Single Digital Patient Record” will commence in March 2026 and will be gradually rolled out.⁵⁴⁹

⁵⁴⁴ Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn - Annexure A at pp. 13-14.

⁵⁴⁵ Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [21].

⁵⁴⁶ Transcript, D2 (Scott): T96.40 – T97.8 (29 April 2025).

⁵⁴⁷ Exhibit 1, Vol 51, Tab 1636, Statement of Dr Brendan Flynn at [31].

⁵⁴⁸ Transcript, D20 (Flynn): T1834.14 – 29 (28 May 2025).

⁵⁴⁹ Transcript, D20 (Flynn): T1834.47 – T1835.5 (28 May 2025).

Queensland co-responder models

2.610 In Queensland, there are currently two co-responder models. Both models aim to provide appropriate supports as an alternative to hospital transport and presentation.⁵⁵⁰ Those two models are as follows:

- (a) **“QAS co-responder model”**: A Queensland Ambulance Service (**QAS**) member is paired with a Queensland Health Clinical Nurse Consultant to attend incidents of low acuity only. This model operates in 11 of the 16 health districts in Queensland;⁵⁵¹ and
- (b) **“QPS co-responder model”**: A Queensland Health Clinical Nurse Consultant attends incidents with QPS officers who are specially trained in mental health and who can attend an incident regardless of the level of acuity. The mental health clinician is able to undertake an assessment in the community, removing the need for hospital attendance for evaluation.⁵⁵²

2.611 The QPS co-responder program is governed under local agreements between the QPS districts and local health districts. Those programs operate similarly but with some nuances. QPS and Queensland Health fund their respective members.⁵⁵³

2.612 On average, three to four calls are made to a co-responder per shift.⁵⁵⁴ A/Deputy Commissioner Mark Kelly of QPS (**A/DC Kelly**) stated that, whilst effective, the QPS co-responder program is resource-intensive and its effectiveness is limited by the complexity of the response required for each attendance.⁵⁵⁵

2.613 A Memorandum of Understanding is in effect between QPS and Queensland Health which provides for the sharing of information. That ability for agencies to share information was identified by A/DC Kelly to be an important part of the co-responder model.⁵⁵⁶

2.614 A/DC Kelly supported expansion of the QPS co-responder model throughout Queensland, although identified there would be barriers including (in addition to resourcing) geographic limitations with isolated small communities.⁵⁵⁷

2.615 The submissions on behalf of QPS regarding Queensland's co-responder models included that QPS is very supportive of both co-responder models in Queensland and commends Queensland's co-responder models to other parts of Australia. QPS identifies there is a need for additional resourcing, however it is very beneficial from a cost-benefit standpoint. Early assessments of the QPS co-responder model (which

⁵⁵⁰ Exhibit 1, Vol 23, Tab 863E, Statement of Inspector Bernard Quinlan at [68].

⁵⁵¹ Transcript, D20 (Kelly): T1797.10 – 14, T1797.28-32 (28 May 2025).

⁵⁵² Transcript, D20 (Kelly), T1797.1-9 (28 May 2025); Exhibit 1, Vol 50, Tab 1622A, Supplementary statement of A/Deputy Commissioner Mark Kelly at [6]; Exhibit 1, Vol 23, Tab 863E, Statement of Inspector Bernard Quinlan at [64]-[65].

⁵⁵³ Exhibit 1, Vol 50, Tab 1622A, Supplementary statement of A/Deputy Commissioner Mark Kelly at [13]-[14]; Transcript, D20 (Kelly): T1798.30-32 (28 May 2025).

⁵⁵⁴ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [66].

⁵⁵⁵ Exhibit 1, Vol 50, Tab 1622A, Supplementary statement of A/Deputy Commissioner Mark Kelly at [19].

⁵⁵⁶ Transcript, D20 (Kelly): T1796:23-31 (28 May 2025).

⁵⁵⁷ Transcript, D20 (Kelly): T1799.49 - T1800.2 (28 May 2025).

operates in seven Queensland police districts) have identified that it should continue and is worthy of a significant allocation of resources.

2.616 The submissions on behalf of QPS also noted:

*Since the hearings in the Inquest, the QPS has asked the Police Minister to write to the Minister for Health and Ambulance Services seeking an increase in clinician resourcing to lift the co-responder service to a two shift per day, seven days a week roster across 13 (out of 16) Police Districts.*⁵⁵⁸

UK co-responder model (Right Care, Right Person)

2.617 The UK's "Right Care, Right Person" (**RCRP**) model is the primary model currently under consideration by the NSWPF for NSW.⁵⁵⁹

2.618 The RCRP model is designed to "make sure that people of all ages who have health and/or social care needs are responded to by the right person, with the right skills, training, and experience to best manage their needs."⁵⁶⁰ In the UK, the RCRP model took into account legal advice obtained regarding duties of care and where it would be most appropriate for certain agencies to attend calls for service.⁵⁶¹

2.619 The RCRP model creates a threshold which is used to assist police in determining whether it is appropriate for them to respond to mental health-related incidents. Under the RCRP model, police will respond:⁵⁶²

- (a) To investigate a crime that has occurred or is occurring; or
- (b) To protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

2.620 The NSWPF review stated that the advantages of the RCRP model include:⁵⁶³

- (a) It is a consumer-centric and trauma informed approach;
- (b) It provides for engagement by appropriately skilled and trained experts with the knowledge to assess and treat affected persons appropriately;
- (c) It reduces stigma associated with a uniformed police response;
- (d) It reduces the need for use of force and restraint by police officers; and
- (e) It allows reinvestment in core police functions and crime prevention.

2.621 Supt Hales gave the following evidence about how the RCRP model operates in practice:

⁵⁵⁸ Written submissions on behalf of the Commissioner of QPS at [54].

⁵⁵⁹ Exhibit 1, Vol 50, Tab 1626, Statement of Superintendent Kirsty Hales at [47].

⁵⁶⁰ Exhibit 1, Vol 49, Tab 1615, Summary Internal Review of the NSWPF at p. 9.

⁵⁶¹ Exhibit 1, Vol 49, Tab 1615, Summary Internal Review of the NSWPF at p. 10.

⁵⁶² Exhibit 1, Vol 49, Tab 1615, Summary Internal Review of the NSWPF at p. 10.

⁵⁶³ Exhibit 1, Vol 49, Tab 1615, NSWPF review at p. 10.

If a call were to come through and let's say for example the call is triaged to police, so the caller requests police attendance, the call would then be triaged using a detailed triage system that identifies risk, threat, risk to the individual, risk to anyone attending, what the nature of the call is, and then an appropriate referral to either ambulance services or NHS111.

*Then that matter might be triaged by those agencies as to what the appropriate response is, does that require attendance on scene or is it just going to be intervention via telephone. And then if someone does attend on scene and there is a risk identified, then a request for police assistance.*⁵⁶⁴

2.622 In response to a question with respect to whether any such calls would be met with a co-response from more than one agency, Supt Hales said:

Yes. So, co-response we could put a number of ways. Let's just assume that the call comes in and it might require both police and ambulance attendance, then the position in the UK is that if it's a health response, then ambulance will remain lead agency but police will assist deployment in the field until such time that that environment is deemed safe, and then police will remove themselves.

*It might be the case that ambulance are on scene and a risk is identified and they request police and we will attend. Or it might be the case where police are requested, it meets threshold for police attendance and we attend, but we request assistance of ambulance to come in terms of transport or engagement with the consumer. Or police are on scene, we might require engagement, such as the Queensland model or the Mental Health Line at the moment, where we would tap into accessing a clinician for advice on scene via a telephone call.*⁵⁶⁵

2.623 In terms of whether NSW Health is supportive of the RCRP model being implemented, Dr Flynn gave evidence that:

Yes, we support a health led model. We agree that, you know, there are many situations where an individual in distress in the community is much better served by a health model than a police model notwithstanding the comments around needing to ensure the safety of everybody if there's any suggestion of imminent risk. So I guess the answer ... is yes, with the caveats around community and staff risk.

...

*... I think having a sorting process upstream at triple-0 is extremely important, and I also think having the capacity for police officers 24/7 anywhere to be able to contact a mental health expert who ideally has access to that person's records if they've got one, I think both of those are good ideas.*⁵⁶⁶

⁵⁶⁴ Transcript, D20 (Hales): T1846.11 – 20 (28 May 2025).

⁵⁶⁵ Transcript, D20 (Hales): T1846.28 – 42 (28 May 2025).

⁵⁶⁶ Transcript, D20 (Flynn): T1847.12 – 17, T1847.34-38 (28 May 2025).

Submissions and proposed recommendations regarding co-responder models

Counsel Assisting's submissions

2.624 Counsel Assisting submitted:

Both New South Wales and Queensland are working with co-responder models to try and ensure the right expertise and resources are available, but in both States, greater resources are required. And that was acknowledged very frankly by both service providers.

The Queensland Police Force submissions provide that the police have worked to establish structured services and programs to support and train frontline officers responding to mental health call outs. But even with the most excellent training and equipment, it is not the core business of police, or if it's part of their core business now, it is not what has been the core business previously, and they do not profess to be the experts in the area and want co-responder models that will provide them with expertise in the field and help to relieve the burden.⁵⁶⁷

2.625 Counsel Assisting did not submit that a recommendation should be made to the Queensland Government regarding co-responder models, noting the efforts being made in Queensland at present, and I do not consider that such a recommendation would be necessary or desirable.⁵⁶⁸

2.626 In relation to-responder models in NSW, Counsel Assisting submitted as follows:

... the Counsel Assisting team recognises the significant work that is being done to support the RCRP model and the recognition by NSWPF that their members are not always the right persons to respond - from the perspective of both the consumer and NSWPF. Those police are required to respond to a significant increase in call outs which relate to people experiencing a mental health incident or emergency and for which there was not an associated criminal offence. By way of a reminder of these troubling figures (as set out above in respect of 2022) police responded to 61,164 mental health incidents where no criminal behaviour was involved, an 41% increase compared to 2018.

While Counsel Assisting do not wish to cut across the broader reform agenda based on RCRP, it appears that there are areas in NSW in urgent need of a co-responder service that are missing out, while the discussions about resource allocation for particular models continues. This is the case even though the PACER teams have been positively evaluated and well received by police on the ground.⁵⁶⁹

2.627 Counsel Assisting accordingly proposed the following recommendation (Proposed Recommendation 19):

⁵⁶⁷ Transcript, Closing Submissions D1: T1922.43-T1923.6 (25 November 2025).

⁵⁶⁸ Written submissions of Counsel Assisting at [2923].

⁵⁶⁹ Written submissions of Counsel Assisting at [2948]-[2949].

Proposed Recommendation 19: To the NSW Government

That the NSW Government model, cost and support the roll out of PACER teams, or (if applicable) an alternative co-responder model best suited to the Local Area Command, so that they are widely available throughout NSW.

NSW Health and NSWPF's submissions

2.628 It was submitted on behalf of NSW Health that Counsel Assisting's written submissions fairly summarise the evidence regarding the impact on policing and advent of mental health co-responder models such as PACER.⁵⁷⁰

2.629 The submissions on behalf of the NSWPF noted Counsel Assisting's Proposed Recommendation 19 and that Counsel Assisting do not want to cut across broader reform, and emphasised the following aspects of Supt Hales' and Dr Flynn's evidence:⁵⁷¹

- (a) *in the last five years, a number of reviews and inquiries have been undertaken across Australia in relation to the mental health system and the involvement of police in mental health crisis intervention;*
- (b) *the outcome of these reviews and inquiries indicate that police are often not the best-placed agency to respond to a mental health incident in the community, and police as primary responders increases the risk of adverse outcomes for mental health consumers;*
- (c) *for this reason, the position of the NSWPF is that the primary focus should be on the development of a health-led response to mental health incidents based on the RCRP Model utilised in the UK;*
- (d) *NSW Health is also in favour of a health-led model, subject to certain caveats around risk for attending clinicians; and*
- (e) *Superintendent Hales and Dr Flynn are part of various working groups developing a "whole of government approach". Models including RCRP are under consideration but further detail on this is currently confidential, and appropriately so.⁵⁷²*

2.630 In relation to proposed Recommendation 19 (as well as proposed Recommendation 5), NSW Health and NSWPF jointly submitted:⁵⁷³

- (a) The evidence before the Inquest demonstrates there is already a review process underway to consider response options to mental health incidents in the community, including models such as "PCCMHL" (addressed in Part 3) and PACER;

⁵⁷⁰ Written submissions on behalf of NSW Health and NSW Ambulance at [9]-[10].

⁵⁷¹ Written submissions on behalf of NSW Police Force at [87]-[88].

⁵⁷² Written submissions on behalf of NSW Police Force at [87]-[88].

⁵⁷³ NSWPF, NSWA and NSW Health position on joint recommendations at pp. 1-2.

- (b) That process will include detailed consideration of all of the different options, including assessment as to their feasibility in NSW. The evidence before the Inquest was (understandably) more limited in this respect;
- (c) In light of this, the proposed recommendations by Counsel Assisting relating to the implementation of specific models may not be necessary; and
- (d) In the event I consider that a recommendation is appropriate, it is submitted that should take the following (broader) form in light of the evidence of Supt Hales and Dr Flynn as to the limitations of a PCCMHL model in NSW and the likely benefits of a health-led response:

“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.”

Findings

- 2.631 I have determined to make a recommendation in the terms proposed by NSWPF and NSW Health directly above. This recommendation is made in Part 3 (as recommendation 11).

Community mental health care

Outreach services

- 2.632 Counsel Assisting submitted that whilst Mr Cauchi interacted briefly with NSWPF and other services aimed at those sleeping rough, *“there was no outreach model to assist him with accommodation and very few accommodation options even if he had been spoken to by a mental health specialist”*.⁵⁷⁴
- 2.633 Counsel Assisting submitted that Professor Nielssen gave compelling evidence about the decrease in outreach services for mentally ill persons,⁵⁷⁵ which there is a pressing need to address, and that:

*Professor Nordentoft explained that in Denmark they have a psychiatric emergency outreach facility where psychiatrists can be called by the police or by staff members in [supported] housing facilities. Also, families can call on that outreach service. That's perhaps beyond the imagination of our services at this stage, but it does suggest that getting mental health professionals into the community attending to outreach and linking patients to longer term care should form part of our system.*⁵⁷⁶

⁵⁷⁴ Written submissions of Counsel Assisting at [2952].

⁵⁷⁵ Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [149]. See discussion at Transcript, D16: T1380 (22 May 2025), and Professor Nordentoft at Transcript, D16: T1446 (22 May 2025).

⁵⁷⁶ Transcript, Closing Submissions D1: T1894.42-48 (25 November 2025).

2.634 Counsel Assisting proposed the following recommendation (Proposed Recommendation 2.A(1)):

Proposed Recommendation 2.A: to the NSW Government

- (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, and
 - 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;
 - 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

2.635 I have determined to make this recommendation as proposed by Counsel Assisting (which forms part of recommendation 8 below).

Community health centres

2.636 Professor Nielssen opined:

Improvements in the services available to persons suffering from severe and chronic forms of mental illness could include an improvement in the productivity of community health centres, for example, by the switch from a model of episodes of care to one of lifetime care for people with chronic and relapsing forms of schizophrenia and bipolar disorder who have required regular admission to hospital.⁵⁷⁷

2.637 Counsel Assisting propose the following recommendation (Proposed Recommendations 2.A(2)-(3)):

Proposed Recommendation 2.A: to the NSW Government

...

- (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 to 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:

⁵⁷⁷ Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [152].

- 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 1.B.

Proposed Recommendation 2A

2.638 A statement of Dr Murray Wright (Chief Psychiatrist of NSW, NSW Health) dated 3 December 2025 was provided in this Inquest. That statement sets out the programs and partnerships that the Mental Health Branch of NSW Health is currently involved in with respect to homelessness and also responds to Proposed Recommendation 2A (as previously formulated). Dr Wright’s statement includes the following:⁵⁷⁸

- (a) In 2024, NSW Health commenced a review titled “Review and Planning for Mental Health Services” (RaP-MHS) to provide a comprehensive picture of what mental health services are provided in NSW, where and who they are provided to, and where and what additional services or improvements are most needed. This *“marks the first time that NSW Health has prepared a comprehensive and statewide examination of mental health service provision to support [Local Health Districts] and the Ministry of Health with future service planning and service improvement”*;
- (b) There are currently outreach mental health services (established by NSW Health) which provide care to people experiencing homelessness. NSW Health agrees that, depending on available resources, there is a need to expand those services and/or expand the remit of the existing community mental health teams. Further, *“NSW Health supports additional funding for this sector and also supports a collaborative approach in the development of such services so that they reach as many people as possible. Given that this involves multiple Government agencies, it is appropriate that the Government lead this process with NSW Health involvement as required by Government”*;
- (c) The current service model can include one or more episodes of care with community mental health services, or continuing care for individuals with complex needs. A model of episodic engagement, according to need, is

⁵⁷⁸ Exhibit 1, Vol 54, Tab 1700, Statement of Dr Murray Wright PSM at [17]-[46].

preferable. If all people with treatment resistant schizophrenia were compelled to remain engaged with a community health service for their lifetime, this would have the effect of virtual institutionalisation;

- (d) Within NSW Health's service model, all care is individualised to the consumer. There should not be a "one size fits all" approach for people with a particular diagnosis;
- (e) There is a need for additional resourcing for CHCs, which would 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;
- (f) There is a 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;
- (g) NSW Health does not distribute professional practice guidelines and proposes drawing the attention of services to existing internationally well-regarded guidelines (noting the UK's "NICE" guidelines and the inaugural Maudsley Deprescribing Guidelines released in 2024), rather than seeking to replace those guidelines; and
- (h) Further, *"taking learnings from the findings of this Inquest, NSW Health proposes it provide information to clinicians in the private sector as to pathways and options they have when deprescribing. Beyond this, it is a matter for the clinician as to how they manage the particular patient"*.

2.639 On 9 December 2025, Dr Wright met with available members of the expert psychiatrist panel and Counsel Assisting.

2.640 Counsel Assisting submitted that: *"As a result of that productive discussion, an alternative recommendation 2A was drafted, taking into account input from Dr Wright, Professor Nielssen, Professor Large and Professor Heffernan"*.

2.641 NSW Health have advised those assisting me that NSW Health supports the making of proposed Recommendation 2A in its current form.

Findings

2.642 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”.

- 2.643 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”*.
- 2.644 As noted above, 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.
- 2.645 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.
- 2.646 I have determined to make the recommendation proposed by Counsel Assisting, which is supported by the information in Dr Wright's statement.

RECOMMENDATION

Recommendation 8: To the NSW Government

- (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 to 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.

Part 3

Mr Cauchi's interactions with the Queensland Police Service

Mr Cauchi’s interactions with the Queensland Police Service

3.1. To address the evidence arising in relation to consideration of Issue 7 with respect to Mr Cauchi’s interactions with the Queensland Police Service (**QPS**), this Part will be divided into the following sections:

Section A	Introduction
Section B	Statutory and policy context to Mr Cauchi’s interactions with the QPS
Section C	Supports available to QPS officers during the period of their interactions with Joel Cauchi
Section D	Interactions between Mr Cauchi and the QPS
Section E	Recommendations
Section F	Mr Cauchi’s weapons related applications to the QPS

A. Introduction

3.2. Mr Cauchi had no criminal history. However, during the period in which he resided in Queensland, Mr Cauchi came to the attention of the QPS on a number of occasions over a period of about 22 years.

3.3. Many of these interactions were unremarkable. However, a number were examined in some detail during the Inquest, primarily for the purpose of determining whether they presented an opportunity to facilitate Mr Cauchi's engagement with mental health services.

3.4. This approach reflected the formulation of **Issue 7**, which appeared on the Issues List as follows:

Mr Cauchi's interactions with the NSW and Queensland Police, and the status of his mental health at those times, including whether there were opportunities for early intervention in relation to those interactions.

3.5. At the outset of this Part, it is important to recognise that police officers are increasingly attending on people who are experiencing mental health issues and that these interactions are often challenging and time intensive.

3.6. In Queensland, mental health calls for service have increased by 51.3% between 2016 and 2020,⁵⁸⁰ and in the 2023/24 financial year, the average time spent on a mental health-related call for service was 4.6 officer hours.⁵⁸¹

3.7. The demand on police resources has become so great, Counsel for the Commissioner of QPS submitted to me, that it has transformed what are understood to be the core functions of policing.⁵⁸² Traditionally understood to be the protection of life and property and the detection of crime, these core functions now, it is submitted, incorporate responding to persons in the community dealing with mental health issues.

3.8. Police officers are not mental health specialists and are not trained as such. And it is to be borne in mind that the interactions between police officers in Queensland and NSW and members of the community who are, or appear to be, suffering mental health issues, are occurring against a legislative and policy backdrop that emphasises the principle of least restrictive care. That is, they occur in a context that aims to ensure that a person's rights, choices, and autonomy will be maximised to the extent possible whilst still ensuring their safety and well-being.

3.9. Accordingly, the resources that are available to assist police officers in their interactions with people who may be experiencing mental health issues, such as the QPS officers who interacted with Mr Cauchi, were an important matter examined in the Inquest, and

⁵⁸⁰ Transcript, D6 (Quinlan): T418:25-36 (6 May 2025).

⁵⁸¹ Written submissions on behalf of the Commissioner for QPS at [6].

⁵⁸² Transcript, Closing Submissions D1: T1943.11-20 (25 November 2025).

I have carefully considered this evidence, particularly in the context of my power to make recommendations pursuant to s 82 of the Act.

B. Statutory and policy context to Mr Cauchi's interactions with the QPS

- 3.10. To assist in the consideration of the interactions between Mr Cauchi and QPS officers, it is necessary to outline the legislative powers that apply to police interactions with members of the community, in particular those that may be dealing with mental health issues.

Statutory power to detain a person on mental health grounds

- 3.11. In Queensland, the power of a police officer to detain and transport a person to a care and treatment facility is found in s 157B of the *Public Health Act 2005* (Qld).
- 3.12. Section 157B relevantly provides:

157B Ambulance officer or police officer may detain and transport person

(1) This section applies if an ambulance officer or police officer believes—

- (a) a person's behaviour, including, for example, the way in which the person is communicating, indicates the person is at immediate risk of serious harm; and

Example—

a person is threatening to commit suicide

- (b) the risk appears to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication or another reason; and,

- (c) the person appears to require urgent examination, or treatment or care, for the disturbance.

- (2) For the *Police Powers and Responsibilities Act (2000)*, section 609(1)(a)(i), the police officer may consider advice received from a health practitioner about a person in forming a view as to whether there is an imminent risk of injury to a person.

- (3) The ambulance officer or police officer may detain the person and transport the person to a treatment or care place.

- 3.13. Section 157D of the *Public Health Act* relevantly provides that if the police officer takes the person to a public sector health service facility, "*the officer must immediately make an authority (an **emergency examination authority**) for the person*" (emphasis in original).

- 3.14. A person the subject of an emergency examination authority (**EEA**) may be detained in a public health sector health service facility pursuant to s 157E, for the purposes of an examination by a doctor or health practitioner, pursuant to s 157F.
- 3.15. One notable feature of s 157B is that it does not provide a power to detain and transport a person where that person's behaviour indicates that there may be an immediate risk of serious harm to *another person or persons*. The power is only enlivened where the person's behaviour indicates there is a risk of harm to the person themselves.
- 3.16. The Queensland legislation differs in this respect from analogous provisions in other states, for example, s 22 of the *Mental Health Act 2007* (NSW) and s 232 of the *Mental Health and Wellbeing Act 2022* (Vic), which each provide that the power to detain or take a person into police care and control is enlivened, relevantly, when a view is formed (to the requisite standard) that there is a risk to the person themselves or another person.
- 3.17. In the past, QPS officers have been able to have regard to the risk of harm to others when determining whether to transport a person for an examination.
- 3.18. Section 33 of the now repealed *Mental Health Act 2000* (Qld) provided police officers with a power to take a person to an authorised mental health service for an examination (what was then known as an Emergency Examination Order (**EEO**)) if the police officer reasonably believed that, among other matters, the person had a mental illness and *"because of the person's illness there [was] an imminent risk of significant physical harm being sustained by the person or someone else."*
- 3.19. Section 157B of the *Public Health Act* was introduced in 2017 and was in effect during all the relevant interactions between Mr Cauchi and the QPS examined in this Inquest.
- 3.20. As to why the legislative change occurred, Dr John Reilly, the Chief Psychiatrist of Queensland, stated that a review of the EEO provisions, which formed part of a review of the *Mental Health Act 2000* (Qld), found that a majority of EEOs related to persons affected by alcohol and other drugs, or experiencing a "situational crisis", rather than persons with mental illness.⁵⁸³ Accordingly, placement of the EEA provisions in the Public Health Act:

... has supported a health-based response with persons able to receive crisis care input and combined support as required from acute medical services, mental health, social work and alcohol and other drug services while in the emergency department.

...

*Removing the criteria related to risk of harm to others ... was done on the basis that the risk of harm to others should be responded to by police and criminal justice agencies via other mechanisms outside of health services in the first instance.*⁵⁸⁴

⁵⁸³ Exhibit 1, Vol 52, Tab 1658, Statement of Dr John Reilly at [18].

⁵⁸⁴ Exhibit 1, Vol 52, Tab 1658, Statement of Dr John Reilly at [19]-[20].

3.21. In Queensland, an EEA is one of three pathways to an examination by a doctor or authorised medical health professional (**AMHP**). The second pathway is a voluntary examination, and the third is an Examination Authority (**EA**).

3.22. The QPS Operations Procedure Manual states that:

*When officers consider that a person may need an assessment or treatment by a mental health service provider and where there is no immediate risk to persons or property, officers are to ask the person if they will voluntarily obtain an assessment or treatment before considering other options.*⁵⁸⁵

3.23. An EA may be appropriate where “*there is a concern that a person needs to be assessed but it has not been possible for the person to be examined by a doctor or AMHP*”. An EA is made by the Queensland Mental Health Review Tribunal (**the Tribunal**) and authorises a doctor or AMHP to examine the person without their consent.⁵⁸⁶

3.24. Applications for an EA may be made by the following:

- (a) The administrator of an authorised mental health service;
- (b) A person authorised in writing by an administrator, such as a doctor or AMHP; or
- (c) A person who has received advice, from a doctor or AMHP, about the clinical matters for the person who is the subject of the application.⁵⁸⁷

3.25. Accordingly, a QPS officer may apply to the Tribunal for an EA if they have received advice about the clinical matters for the person. “Clinical matters” is defined in s 502(3) of the *Mental Health Act 2016* (Qld) to mean:

- a. *general information about the treatment criteria, their application to a person, and whether there is a less restrictive way for the person to receive treatment and care for the person’s mental illness; and,*
- b. *whether the behaviour of the person, or other relevant factors could reasonably be considered to satisfy the requirements under s 504(2) for making an examination authority for the person; and,*
- c. *options for the treatment and care of the person; and,*
- d. *how the person might be encouraged to have a voluntary examination relating to the person’s mental illness.*

3.26. If the Tribunal issues an EA, the examination must be conducted within seven days.⁵⁸⁸

⁵⁸⁵ Exhibit 1, Vol 23, Tab 863E, Statement of Inspector Bernard Quinlan, Annexure A, Operational Procedures Manual Chapter 6 at p. 33.

⁵⁸⁶ Exhibit 1, Vol 52, Tab 1658, Statement of Dr John Reilly at [49]-[50].

⁵⁸⁷ *Mental Health Act 2016* (Qld) s 502.

⁵⁸⁸ *Mental Health Act 2016* (Qld) s 505.

C. Supports available to QPS officers during the period of their interactions with Joel Cauchi

- 3.27. During the Inquest, the Court received evidence regarding the supports available to QPS officers to assist them during interactions with members of the public experiencing mental health issues, in particular, the services that were available during the time period when QPS officers interacted with Mr Cauchi.

Police Communications Centre Mental Health Liaison Service

- 3.28. The Police Communications Centre Mental Health Liaison Service (**PCC MHLS**) is a mental health service that supports police in the first response to people in mental health crisis.⁵⁸⁹ It facilitates the provision of mental health information, advice, and assistance to QPS officers at a statewide level.⁵⁹⁰
- 3.29. The PCC MHLS is a partnership between the QPS and Queensland Health, which aims to provide real-time information sharing and support for QPS officers in responding to situations involving people experiencing mental health issues. Clinicians can provide advice on a person's mental health records to assist with the QPS response.⁵⁹¹
- 3.30. Clinicians at the PCC MHLS have access to the Consumer Integrated Mental Health and Addictions application (**CIMHA**), which contains details of persons who have engaged with the Queensland public mental health system. Information (including mental health information held by the public health system) can be shared between the QPS and Queensland Health in accordance with the *Memorandum of Understanding Mental Health Collaboration (2017) (MOU)*.⁵⁹² The MOU is currently being renegotiated, with opportunities for further information sharing being explored.
- 3.31. From 2024, clinicians in the PCC MHLS have been able to access the QPS CAD system (**LCAD**), which has enabled them to review and monitor calls for service and provide timely advice in relation to incidents.
- 3.32. The PCC MHLS commenced operation in January 2015, and its clinical lead is Professor Edward Heffernan,⁵⁹³ who gave expert evidence at this Inquest.
- 3.33. Professor Heffernan gave evidence that the PCC MHLS:

... performs a key role with linkages across police and local mental health services through early referrals and notifications of potential presentations. Importantly, the PCC MHLS can increase situational awareness for frontline Queensland police officers, through the provision of timely mental health information, advice and assistance. The

⁵⁸⁹ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [1.3].

⁵⁹⁰ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [43]-[44].

⁵⁹¹ Exhibit 1, Vol 23, Tab 863E, Statement of Inspector Bernard Quinlan at [60].

⁵⁹² Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [43].

⁵⁹³ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [1.3], [5.5].

*role that the PCC MHLS has in interpreting relevant clinical information and providing this in a way in which it is meaningful and useful to the QPS is invaluable for the immediate management of crisis situations.*⁵⁹⁴

- 3.34. In 2024, there were almost 6,000 clinical interventions through the PCC MHLS.⁵⁹⁵
- 3.35. I will return to the topic of the PCC MHLS in the context of possible recommendations later in this Part.

Mental Health Intervention Co-ordinators

- 3.36. Mental Health Intervention Co-ordinators (**MHICs**) are mental health policing advisors. They provide a means by which the QPS, Queensland Ambulance, and Queensland Health staff can work collaboratively at a district level.
- 3.37. The role of MHIC is performed by a police officer in each Queensland Police District. At the time of the hearing of the evidence, a QPS officer solely performed the role of MHIC in six of the 15 Districts. In the remainder of the Districts, the MHIC was a portfolio performed by an officer who also had other duties.⁵⁹⁶
- 3.38. Responsibilities of a MHIC include:
- (a) Coordinating strategic responses both internally and with partnering agencies, as well as non-government organisations;
 - (b) Facilitating information-sharing and collaboration between the QPS and other agencies regarding mental health and well-being issues;
 - (c) Providing guidance to QPS members on mental health issues within the community;
 - (d) Assisting District Education and Training Officers in the delivery of ongoing mental health training, including related policies and legislation to frontline officers; and
 - (e) Reviewing QPS responses to mental-health related calls for service and making recommendations on strategies to improve outcomes.
- 3.39. MHICs are not able to access CIMHA, however, information sharing occurs with their Queensland Health MHIC counterparts in accordance with the MOU.⁵⁹⁷

⁵⁹⁴ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [5.5].

⁵⁹⁵ Transcript, Closing Submissions D1: T1948:35-39 (25 November 2025).

⁵⁹⁶ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [31]; Transcript, D20 (Kelly): T1801.44 – 47 (28 May 2025).

⁵⁹⁷ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [52].

3.40. A/DC Kelly, Regional Operations and Youth Crime, stated that:

MHICs provide assistance to officers in the assessment and response to mental health incidents and, where necessary, assist with requests for information from Queensland Health and the Queensland Ambulance Service. With the consent of the client, a MHIC, and indeed any officer, can connect vulnerable community members to external support services through the police referral system. This has the benefit of enabling early and effective intervention. This initiative has become an embedded strategy of QPS frontline policing to reduce repeat calls for service and has the longer-term benefits of reducing recidivism and victimisation.⁵⁹⁸

Darling Downs Police District

3.41. Within the Darling Downs Police District, where Mr Cauchi's hometown of Toowoomba is located, the role of MHIC has been performed by Sergeant Tracy Morris (**Sgt Morris**), on a part-time basis, between August 2012 and August 2022, and since that time, on a full-time basis.⁵⁹⁹

3.42. Sgt Morris described the following tasks she would perform on a typical day:

- (a) Review emails to identify any urgent matters.
- (b) Review all calls for service that occurred in the previous 24 hours (or 72 hours on a Monday).
- (c) Review QPRIME to identify what EEAs have been completed. These are then audited to ensure they are articulate, accurate, and compliant with policy and procedure.
- (d) Ensure persons are flagged correctly in the custody reports.
- (e) Review all calls for service that do not fit the mental health occurrence type, such as welfare checks or attendances on persons with intellectual disabilities or other vulnerabilities.
- (f) Triage the above and attend to follow up. This involves undertaking risk assessments and identifying persons who repeatedly come into contact with police and who police know to be a risk to themselves or the community, so that the QPS can re-engage with them.⁶⁰⁰

3.43. Sgt Morris gave evidence that in order to follow up on all the calls she receives, she would require three additional MHICs, which would:

... provide us with a two-shift response to assist with mental health calls for service, second response to jobs assisting general duties, second response to jobs assisting

⁵⁹⁸ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [34].

⁵⁹⁹ Exhibit 1, Vol 23, Tab 855A, Statement of Sergeant Tracy Morris at [3].

⁶⁰⁰ Transcript, D6 (Morris): T402.12 – 38 (6 May 2025). The term "QPRIME" refers to the central records and information system for the QPS, on which officers can record incidents and intelligence.

*[the Queensland Ambulance Service] to free up general duties to go to other calls for service and follow-up engagements with people that themselves are not available during the 8 to 4, 6 to 2 type timeframe.*⁶⁰¹

- 3.44. Insp Quinlan, Domestic, Family Violence and Vulnerable Persons Command, accepted Sgt Morris' evidence. Insp Quinlan also agreed that it would be appropriate to allocate the MHICs according to the level of need in each police district.⁶⁰²
- 3.45. In his oral evidence, A/DC Kelly said a 100-day review was being presently undertaken, and he was "*confident that will improve the numbers of Mental Health Intervention Coordinators to one per district.*"⁶⁰³
- 3.46. I will return to the topic of the resourcing of the MHICs, including discussion of further steps taken by the QPS since the conclusion of the oral evidence, later in this Part.

⁶⁰¹ Transcript, D6 (Morris) : T403.4 – 10 (6 May 2025).

⁶⁰² Transcript, D6 (Quinlan) : T436.40 – 45 (6 May 2025).

⁶⁰³ Transcript, D20 (Kelly): T1802.6 – 10 (28 May 2025).

D. Interactions between Mr Cauchi and the QPS

- 3.47. As stated above, a number of interactions between Mr Cauchi and the QPS were examined in the course of the Inquest. These will be considered in turn.

Erratic driving

- 3.48. The first interaction that was examined at the hearing of the Inquest concerned a traffic stop involving Mr Cauchi that occurred following observations made by a QPS officer that he was driving erratically.
- 3.49. On 9 September 2021, Senior Constable Roy Avenell (**S/Cst Avenell**), Brisbane City Highway Patrol Unit, was performing traffic enforcement duties on a marked police motorcycle.⁶⁰⁴
- 3.50. S/Cst Avenell saw a silver-coloured Toyota Sedan drive past him.⁶⁰⁵ This vehicle was being driven by Mr Cauchi. In relation to the vehicle S/Cst Avenell:

*... observed it to accelerate then brake numerous times for no apparent reason. As I continued to observe the vehicle I could see its rear brake lights continue to go on and off and the vehicle lean forward indicating that the driver was braking momentarily before releasing the brakes and driving forward again. The vehicle then changed lanes into the right turn lane quite abruptly all the while continuing its previous action of applying and releasing the brakes repeatedly before coming to a stop behind traffic.*⁶⁰⁶

- 3.51. Concerned that the driver may have been under the influence of something or suffering some kind of medical episode, S/Cst Avenell activated his lights and sirens and intercepted the vehicle.⁶⁰⁷
- 3.52. S/Cst Avenell asked the driver, Mr Cauchi, why he had been driving erratically, to which Mr Cauchi replied that he did not realise he was driving like that.⁶⁰⁸ S/Cst Avenell thought Mr Cauchi to be “a little erratic and nervous in his behaviour.”⁶⁰⁹
- 3.53. Mr Cauchi presented his licence, and S/Cst Avenell noticed that it indicated a medical condition and asked to see his medical certificate. Mr Cauchi produced the certificate on which no particular medical condition was noted.⁶¹⁰
- 3.54. S/Cst Avenell accessed Mr Cauchi's record on QPRIME and recalled seeing an alert indicating that Mr Cauchi had been diagnosed with schizophrenia but was not taking

⁶⁰⁴ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [2], [4].

⁶⁰⁵ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [4].

⁶⁰⁶ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [5].

⁶⁰⁷ Transcript, D5 (Avenell): T321.27, 42-46. (5 May 2025).

⁶⁰⁸ Exhibit 1, Vol 23, Tab 846, BWV Footage of Senior Constable Roy Avenell, Annexure A at p. 1.

⁶⁰⁹ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [9].

⁶¹⁰ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [10].

medication. He further recalled seeing a previous incident relating to erratic driving, “*but that was, I think, 12 months prior or something like that.*”⁶¹¹

- 3.55. A roadside drug test was conducted, which returned a negative result. Whilst undertaking the drug test, S/Cst Avenell asked Mr Cauchi if he suffered any medical conditions, to which he said words to the effect of “[a] whole heap of mental illness”.⁶¹² Mr Cauchi said he was not taking any medication, but that he had been “*put on medication when [he] was 17*” and later “*came off*” it.⁶¹³
- 3.56. S/Cst Avenell advised Mr Cauchi to improve his manner of driving and returned to his motorcycle. Mr Cauchi then departed.⁶¹⁴
- 3.57. When asked whether, if he had been aware that Mr Cauchi had been stopped for erratic driving on 10 October 2020 and 6 November 2020, he would have taken any further action, S/Cst Avenell said:

*I believe so, yes ... it would have been a lot easier to see a pattern of behaviour because, as I look on my QLiTE or ... my device, all the records are there, and if I was trying to ascertain that pattern, I would have to go through every single record and go through every single report, and sometimes you can't do that on the side of the road. You don't have the time or sort of, you know, the ability to do that. But, yeah, if, if I'd have been aware that this was a pattern of behaviour and obviously there were some mental health issues, I, I would have probably looked into it a bit deeper.*⁶¹⁵

- 3.58. When asked what he would have done had he known of the previous erratic driving incidents, S/Cst Avenell told the Court:

*As a traffic officer, I mean I can, I can apply to Queensland Health. I can contact Queensland Health to I guess have him appear a sort of show cause hearing as to why he should hold a licence. This is kind of my limit as to what I can do roadside. Unfortunately, with, with the way the legislation is worded, I, I didn't deem him a risk of harm to other persons at that point, or himself, and so I was kind of tied in relation to if I could take any further action in relation to an emergency examination assessment.*⁶¹⁶

- 3.59. S/Cst Avenell agreed that he could have contacted Mr Cauchi's doctor to make sure that there was a further assessment of him and that he could have obtained the doctor's details from Queensland Transport.⁶¹⁷
- 3.60. Insp Quinlan was of the view that S/Cst Avenell complied with QPS policies and procedures and that Mr Cauchi did not, at that time, fit the criteria for an EEA. Insp Quinlan said that, unfortunately, there are a lot of bad drivers on the roads and that three

⁶¹¹ Transcript, D5 (Avenell): T324.5 – 7, 27 – 30. (5 May 2025).

⁶¹² Transcript, D5 (Avenell): T323.4 – 6 (5 May 2025).

⁶¹³ Exhibit 1, Vol 23, Tab 846, BWV Footage of Senior Constable Roy Avenell, Annexure A, at p. 2; Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [12]–[13].

⁶¹⁴ Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [15].

⁶¹⁵ Transcript, D5 (Avenell): T325.45 – T325.7 (5 May 2025).

⁶¹⁶ Transcript, D5 (Avenell): T326.27 – 33 (5 May 2025).

⁶¹⁷ Transcript, D5 (Avenell): T326.46 – T327.3 (5 May 2025); Exhibit 1, Vol 23, Tab 845A, Statement of Senior Constable Roy Avenell at [17].

interactions that have not resulted in a traffic incident are unlikely to attract the show cause provision.⁶¹⁸

- 3.61. Insp Quinlan said that S/Cst Avenell “possibly” could have followed up with a MHIC, and that a further available option was to create a mental health street check. He told the Court:

*... there’s an ability to add a mental health flag and create a mental health street check, which can either be followed up by a Queensland Police Intelligence Unit, who would see the mental health interaction or the flag, and then direct it to a Mental Health Intervention Coordinator, or if it’s reviewed in the district by the Mental Health Intervention Coordinator.*⁶¹⁹

- 3.62. A/DC Kelly agreed with Insp Quinlan and further stated that even when considering this interaction together with the two other interactions relating to erratic driving (10 October 2020 and 6 November 2020), Mr Cauchi was not exhibiting behaviour that demonstrated an immediate risk of serious harm such that he required an EEA.⁶²⁰
- 3.63. In relation to the evidence of the expert psychiatrists, Professor Nordentoft stated that this interaction indicated that Mr Cauchi was not well functioning, but that the manifestation was unspecific and not typical of schizophrenia. She opined that although Mr Cauchi may have been psychotic during this interaction, it cannot be expected that police officers are able to identify an underlying psychotic condition.⁶²¹
- 3.64. Professor Heffernan stated that the instances where Mr Cauchi was pulled over for erratic driving, including on 9 September 2021, were opportunities for police to have directed Mr Cauchi into mental health care or to have obtained further information about his mental health to inform their responses to him. Professor Heffernan stated that the PCC MHLS could have been beneficial to provide information about Mr Cauchi’s prior contact with mental health services.⁶²² S/Cst Avenell agreed with Professor Heffernan’s evidence about the potential utility of the PCC MHLS in these circumstances.⁶²³

Submissions

- 3.65. Counsel Assisting submit that there was no basis for an EEA at this time. However, by the time of the traffic stop by S/Cst Avenell on 9 September 2021, there was sufficient information to indicate that Mr Cauchi’s poor functioning led to erratic driving, which caused a risk to the public. With the benefit of hindsight, this was an opportunity to divert Mr Cauchi back into the health system by requiring him to see a doctor in order to keep his licence.

⁶¹⁸ Transcript, D6 (Quinlan): T427.12-17 (6 May 2025).

⁶¹⁹ Transcript, D6 (Quinlan): T426.28 – 33 (6 May 2025).

⁶²⁰ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [92]-[95].

⁶²¹ Exhibit 1, Expert Volume, Tab 14, Report of Professor Merete Nordentoft at [56].

⁶²² Exhibit 1, Expert Volume, Tab 8 Report of Professor Edward Heffernan at [7.4.1]-[7.4.2].

⁶²³ Transcript, D5 (Avenell): T327.25 - 31 (5 May 2025).

- 3.66. Counsel Assisting does not suggest that S/Cst Avenell could have foreseen the type of harm that Mr Cauchi would eventually cause, but that reviewing his conduct longitudinally allowed for a greater understanding of the risk. By the time S/Cst Avenell spoke with Mr Cauchi, it was the third time he had been pulled over for erratic driving.
- 3.67. Counsel Assisting submit that S/Cst Avenell gave thoughtful evidence that, on reflection, he could have obtained the doctor's details from the medical certificate or from Queensland Transport.
- 3.68. Counsel Assisting submit that since there is no evidence that this problem is widespread, there is no basis for a formal recommendation. However, QPS are on notice of this issue and should make an assessment about whether officers specialised in traffic patrols are adequately trained in what to do where they are concerned that erratic driving is linked to a mental health condition that may be undertreated.
- 3.69. Mr Gnech, legal representative for S/Cst Avenell, submitted that no adverse comment should be made in relation to his client. It should be acknowledged that traffic incidents of the nature that occurred on 9 September 2021 occur hundreds, if not thousands, of times a day across Australia. Absent the tragic events of 13 April 2024, no person, coroner or otherwise, would have taken issue with the manner in which S/Cst Avenell conducted the traffic stop.
- 3.70. Mr Gnech submitted that S/Cst Avenell's conduct was appropriate and consistent with standard police practice; however, in hindsight, given the events of 13 April 2024, it has been characterised as a missed opportunity.
- 3.71. Counsel for the Commissioner, QPS, submits that during the interactions, Mr Cauchi did not display any behaviours which would indicate a mental health crisis or distress. Counsel submits it is an accurate observation that, with the benefit of hindsight, reviewing Mr Cauchi's conduct longitudinally would have allowed for a greater understanding of the risk he was starting to pose. Counsel submits, however, that there are limits to what an officer can do roadside and that the fact that there are just bad drivers cannot be discounted.
- 3.72. Counsel for the Commissioner, QPS, accepts that had the 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. However, it is unknown whether a different response by S/Cst Avenell would have diverted Mr Cauchi back into the health system by requiring him to see a doctor in order to keep his licence.
- 3.73. Counsel for the Commissioner, QPS submits that, overall, the conduct and response of S/Cst Avenell was appropriate, taking into account the information he was able to access and appreciate in the time available roadside. The response could have been improved by use of the mental health flag.

- 3.74. Counsel for the Commissioner QPS informed the Court that on 16 October 2025, a notification authorised by Insp Quinlan, entitled “Importance of Mental Health Flags in QPRIME”, was sent to all QPS members, which stated:

This is a reminder of the critical importance of accurately creating and applying Mental Health related flags in QPRIME.

A recent review of operational responses has identified instances where the presence of a mental health flag could have enhanced the effectiveness and safety of police engagement.

This reinforces the value of mental health flags in providing context, supporting risk assessment, and ensuring our responses are appropriate, informed and in line with best practice.

Mental health flags play a key role in improving future interactions with individuals who be experiencing mental health challenges. This applies across all areas of policing, including First responders, Highway Patrol, Specialist Commands, and investigative areas QPS.

*Officers are encouraged to familiarise themselves with the criteria and process for flag creation within QPRIME.*⁶²⁴

Findings

- 3.75. S/Cst Avenell’s handling of the interaction with Mr Cauchi on 9 September 2021 was appropriate. I accept the submission that there were not sufficient grounds for an EEA at this time. I accept also that S/Cst Avenell could not have foreseen the harm that Mr Cauchi would ultimately come to cause on 13 April 2024.
- 3.76. 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. I accept the submission of the Commissioner of QPS, that 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.
- 3.77. This interaction emphasises the importance of the use of mental health flags, and I note the steps taken to remind, and further educate, officers of the QPS about their creation and use. I commend the proactivity of the QPS in taking steps to address this issue.

⁶²⁴ Transcript, Closing Submissions D1: T1951.15-23 (25 November 2025).

The School

- 3.78. On 27 July 2022, the QPS Crime Stoppers Unit entered an intelligence submission linked to a Crime Stoppers report from a staff member of an all-girls boarding school located in Toowoomba.⁶²⁵
- 3.79. There is no evidence to suggest that prior to the contacts referred to in the Crime Stoppers report, Mr Cauchi had any connection to the school, any of its students, or its staff.
- 3.80. A report was made about a man and *"the persistent nature of this individual and the fact [the school was] an all girls boarding school."*⁶²⁶ This man was later identified to be Mr Cauchi.
- 3.81. Mr Cauchi was reported to have initially contacted the school via the school's swim club Facebook page using Facebook Messenger. He sent a message requesting to be a spectator at the Darling Downs Regional Carnival. It was reported that staff had ignored the message, however, on 26 July 2022, Mr Cauchi attended the school sports centre reception. He advised the staff that he had messaged on Facebook about watching the carnival but had not received a reply.⁶²⁷
- 3.82. The staff member informed Mr Cauchi that he would have to contact Darling Downs Swimming as they were hiring the school's facilities. Mr Cauchi then asked the staff member if he could watch basketball and was told that she had no information about that, as the club hired the school's facilities.⁶²⁸
- 3.83. On 27 July 2022, Mr Cauchi called the school to ask whether they sold coffee. He attended the school that afternoon and spoke with the same staff member. Mr Cauchi asked where the netball courts were located. He then asked where he could find a toilet and proceeded towards the doors of the sports centre. The staff member informed Mr Cauchi that a closed training session was underway and that no spectators were permitted.⁶²⁹
- 3.84. Mr Cauchi left and then a short time later returned and asked another staff member about gymnastics. Mr Cauchi was informed that they did not have a gymnastics program.⁶³⁰
- 3.85. Later that day, the staff member spoke with an official from the Toowoomba Netball Association, who informed her that they had also received a message from Mr Cauchi, via Facebook Messenger, asking about whether he could spectate. The staff member

⁶²⁵ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495; Exhibit 1, Vol 22, Tab 819, Statement of Acting Assistant Commissioner Roger Lowe at [69]-[77].

⁶²⁶ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 2.

⁶²⁷ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 2.

⁶²⁸ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 2.

⁶²⁹ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at pp. 2 - 3.

⁶³⁰ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 3.

was informed that the Association had responded and had advised Mr Cauchi that it was a closed session.⁶³¹

- 3.86. The staff member provided the QPS with a copy of Mr Cauchi's Facebook profile picture and a still image recorded by CCTV cameras of Mr Cauchi inside the school's sports centre.⁶³²
- 3.87. The Crime Stoppers intelligence submission was forwarded to the Toowoomba Intelligence Office, where officers confirmed the man was Mr Cauchi.⁶³³
- 3.88. No offences were identified as having been committed. Mr Cauchi's conduct was recorded as "*concerning behaviour*".⁶³⁴
- 3.89. The Toowoomba Intelligence Office made a number of unsuccessful attempts to contact Mr Cauchi before the submission was closed on 28 December 2022.⁶³⁵
- 3.90. Insp Quinlan stated that, having regard to the mental health flag then in place on QPRIME for Mr Cauchi, and with the benefit of hindsight, it would have been better to provide the intelligence report to the district MHIC for additional review and appraisal. This was because:

*That would allow a more holistic review. Our memorandum of understanding with Queensland Health in section 5 describes a mental health incident as a series of events. So that, coupled with the other information, would then inform the Mental Health Intervention Coordinator, who would seek further advice from Queensland Health.*⁶³⁶

Submissions

- 3.91. Counsel Assisting submit that the Court would embrace the conclusion of Insp Quinlan, who was a thoughtful and thorough witness. Mr Cauchi's behaviour in seeking access to school-aged children ought to have raised more concern, and triggered action to assess the level of risk involved. Against the background of other incidents of which the QPS were aware (three incidents where he was pulled over for erratic driving; a home visit after a call made by a neighbour when they could hear a male screaming; and the "*caution*" that was on Mr Cauchi's QPRIME profile with a notation "*Diagnosed schizophrenia who doesn't take medication*"), this report should have triggered further investigation.
- 3.92. Counsel Assisting submit it is not possible to know whether intervention by the MHIC would have led to Mr Cauchi receiving a mental health assessment and being connected

⁶³¹ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 3.

⁶³² Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 3; Exhibit 1, Vol 23, Tab 863B, Screenshot of Joel Cauchi's Facebook Profile; Exhibit 1, Vol 23, Tab 863C, Photo of Joel Cauchi.

⁶³³ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 7.

⁶³⁴ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 7.

⁶³⁵ Exhibit 1, Vol 23, Tab 848, QPRIME Intelligence Submission Report, QI2201279495 at p. 8.

⁶³⁶ Transcript, D6 (Quinlan): T428.39 – 45 (6 May 2025). See also, Exhibit 1, Vol 23, Tab 863E, Statement of Inspector Bernard Quinlan at [32]-[33].

back to treatment. They submit, however, that this does appear to be a missed opportunity to intervene and assess his circumstances given the risk factors.

- 3.93. Counsel Assisting submit this underscores the need for, first, a system that encourages police employees who are assessing the risk of any one incident to review the circumstances holistically and, secondly, a well-funded and integrated system that provides sufficient resources for that to take place.
- 3.94. Counsel for the Commissioner, QPS, submitted that the QPS response was reasonable in the circumstances. Counsel notes Insp Quinlan's evidence that better practice would have been for the MHIC to have been informed to allow for a more holistic review, including seeking further information from Queensland Health, and acknowledges that this would have been a constructive initiative.
- 3.95. Counsel for the Commissioner, QPS, submitted that as Counsel Assisting have identified, it is not possible to know whether intervention by a MHIC would have led to Mr Cauchi receiving a mental health assessment. Counsel further submits that it is not possible to know whether a holistic approach would have triggered further investigation.
- 3.96. Counsel for the Commissioner, QPS, submits that in all other respects, the QPS response to the Crime Stoppers Report was appropriate.

Findings

- 3.97. Insp Quinlan's evidence was 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. This was an appropriate concession, and I commend Insp Quinlan for his thoughtful reflection. The information provided by the School should have raised more concerns.
- 3.98. As recognised by Insp Quinlan, this report warranted a more holistic review and assessment, in particular, given the mental health flag on QPRIME in relation to Mr Cauchi. I accept the submission, however, I accept 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 treatment for his mental health.

Attendance at the Cauchi family home on 8 January 2023

- 3.99. The most significant interaction between Mr Cauchi and the QPS occurred on 8 January 2023, when two officers, Senior Constable Matthew McDonnell (**S/Cst McDonnell**) and Senior Constable Hope Porter (**S/Cst Porter**), attended the Cauchi family home in response to a report by Mr Cauchi that his father had stolen his knives. Mr Cauchi was, at that time, living with his parents in Toowoomba.
- 3.100. In the course of their attendance at the residence, at which they arrived around 7:00pm, S/Cst McDonnell and S/Cst Porter spoke with Mr Cauchi, his mother, Michele, and his father, Andrew. Like Mr Cauchi's interaction with S/Cst Avenell, the attendance on 8

January 2023 was captured on body-worn video which was activated by each of the attending officers. They were at the home for around 40 minutes.

- 3.101. When the officers arrived, Mr Cauchi was standing outside the front of the home with a backpack on. Mr Cauchi told the officers that his father had taken some of his property and that he wanted to report a crime. Mr Cauchi said that despite trying to negotiate with his father, his father had refused to give the property back.⁶³⁷
- 3.102. S/Cst McDonnell initially assessed that Mr Cauchi did not present as dishevelled or erratic. He was not aggressive and was “quite calm” and “quite reasonable.”⁶³⁸
- 3.103. When initially asked which property his father had taken, Mr Cauchi stated, “[u]m, yeah, um, it is, so military, uh, collector’s items”.⁶³⁹ When asked further about the items, Mr Cauchi said, “[y]eah, it varies. A, so yeah, there’s a US K bar, like some sheaths. Um so ...” and “US <inaudible> knives, knives.”⁶⁴⁰
- 3.104. Mr Cauchi told the officers he had been living with his parents for nearly a year and that he had moved back home after living in Brisbane, where he said he had been studying.⁶⁴¹ S/Cst McDonnell continued to speak with Mr Cauchi while S/Cst Porter separately spoke with Mrs Cauchi, who had come out of the house and was standing in the front yard.
- 3.105. Mr Cauchi told S/Cst McDonnell that he had arrived home from getting groceries when his father told him he had been through his belongings and had taken the knives and removed them from the property.⁶⁴² He reported having an otherwise “pretty good” relationship with his parents.⁶⁴³
- 3.106. Mr Cauchi told S/Cst McDonnell that he was receiving the Disability Support Pension from Centrelink for a mental illness that he had been diagnosed with when he was 17 years old.⁶⁴⁴ He said, “[a]nd since then they did some more tests. They made a mistake in the beginning.”⁶⁴⁵
- 3.107. In response to S/Cst McDonnell asking Mr Cauchi how his mental health was, Mr Cauchi said, “actually it’s been really good”, “it’s been, um, terrific actually. Really good.”⁶⁴⁶ When asked, Mr Cauchi admitted that he did not have a case worker and wasn’t “seeing anyone right now”, nor was he taking any medication.⁶⁴⁷ Mr Cauchi said that his medication was dropped down, and then after being tested it was determined that he no longer needed it.⁶⁴⁸

⁶³⁷ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 1.

⁶³⁸ Transcript, D5 (McDonnell): T338.25 – 30 (5 May 2025).

⁶³⁹ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 1.

⁶⁴⁰ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 1.

⁶⁴¹ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 2.

⁶⁴² Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 3 - 4.

⁶⁴³ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell p. 5.

⁶⁴⁴ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 5.

⁶⁴⁵ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 5.

⁶⁴⁶ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 7 - 8.

⁶⁴⁷ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 8.

⁶⁴⁸ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 8.

- 3.108. S/Cst McDonnell noted that Mr Cauchi's QPS profile referred to him having a weapons licence. Mr Cauchi denied this when asked about it.⁶⁴⁹
- 3.109. Mr Cauchi repeatedly told S/Cst McDonnell that he could not afford for the knives to be taken from him, that they were very expensive, and that he was worried about the financial implications of not having possession of them.⁶⁵⁰ Mr Cauchi said he wanted the knives back immediately, but could not provide the officer with a rational explanation for why he needed them or why their removal was financially affecting him.⁶⁵¹
- 3.110. S/Cst McDonnell began to form a view that there were aspects of what Mr Cauchi was saying about the knives that did not make sense. S/Cst McDonnell said that:
- ... at that point [Mr Cauchi] started to become a little more fidgety and sort of he was – you could obviously see his thought process trying to think about trying to find an answer to those questions. He was probably a bit more disorganised at that point.*⁶⁵²
- 3.111. Mr Cauchi told S/Cst McDonnell that, in his view, what his father had done constituted theft and that he wanted to report it as a crime.⁶⁵³ Mr Cauchi said that his father was very angry and upset when they had a discussion about the knives being removed and said that his father tried to hit him. Mr Cauchi said he was trying to defend himself during the incident.⁶⁵⁴
- 3.112. Mrs Cauchi told S/Cst Porter that she was very concerned about Mr Cauchi's declining mental health. She said that Mr Cauchi had schizophrenia but was not taking any medication. Mrs Cauchi said that Mr Cauchi was unwell and that they (his parents) had been trying to get help for him but were not sure how to do this.⁶⁵⁵
- 3.113. Mrs Cauchi said that Mr Cauchi Snr had taken the knives from Mr Cauchi because he was concerned about Mr Cauchi having access to the knives when he was mentally unstable.⁶⁵⁶ Mrs Cauchi went on to state that she thought her husband was a bit paranoid and that she did not actually think Mr Cauchi would do anything with the knives.⁶⁵⁷
- 3.114. Mrs Cauchi said that Mr Cauchi Snr had given the knives to a friend to look after them and had intended to give them back to Mr Cauchi when his behaviour stabilised. She told S/Cst Porter that Mr Cauchi was in a rage when he found out the knives had been taken and had pushed her and Mr Cauchi Snr around. She said he was screaming, saying that he was going to be bankrupt and end up on the street and be killed.⁶⁵⁸ Mrs Cauchi said

⁶⁴⁹ Exhibit 1, Vol 23, Tab 855 - BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 6.

⁶⁵⁰ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 1, 3, 4, 13, 15.

⁶⁵¹ Exhibit 1, Vol 23, Tab 855 - BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 13, 15.

⁶⁵² Transcript, D5 (McDonnell): T338.42 – 45 (5 May 2025).

⁶⁵³ Exhibit 1, Vol 23, Tab 855 - BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 1, 13, 15, 17, 20.

⁶⁵⁴ Exhibit 1, Vol 23, Tab 855 - BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at p. 12.

⁶⁵⁵ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 2.

⁶⁵⁶ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 3.

⁶⁵⁷ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 3.

⁶⁵⁸ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 4.

Mr Cauchi had also called her a “*bitch*”. She said this was the first time that Mr Cauchi had been physically violent in this way towards her and Mr Cauchi Snr or had spoken to her in that manner.⁶⁵⁹

- 3.115. Mrs Cauchi explained that Mr Cauchi had been in hospital when he was 17 years old and had been compliant with taking medication until he was taken off it slowly (over a period of five years) before ceasing all medication three years earlier.⁶⁶⁰ She went on to state that in relation to Mr Cauchi's psychiatrist weaning him off medication:

*But I think the idea was to monitor him when he came off it. Um, but he came, moved out into a unit when he didn't have the side effects anymore. And, um, he um, he moved into a unit and then took off to Brisbane when he came off medication, because I think he was going to be, she was going to monitor him. She should have been monitoring him ... But he went to Brisbane. I don't know if he's seen a doctor since...*⁶⁶¹

- 3.116. Mrs Cauchi said that they were concerned as Mr Cauchi had been waking up in the middle of the night. She suspected he was hearing voices as he was making noises and stamping his feet. She said that Mr Cauchi desperately needed to see a doctor and be back on medication and that “*he's gone too far now. He doesn't know he is sick.*”⁶⁶²
- 3.117. Mrs Cauchi said that Mr Cauchi needed to go to hospital, but that she did not know how they would get him treatment unless he did something “*drastic*”.⁶⁶³ S/Cst Porter said that police could try to put through some “*referrals*” for Mr Cauchi to speak to people and get some help.⁶⁶⁴
- 3.118. S/Cst Porter said that Mrs Cauchi was “*very forthcoming*” with her about Mr Cauchi and that “*she was asking for help.*”⁶⁶⁵
- 3.119. S/Cst Porter also spoke briefly with Mr Cauchi Snr, who said that he wanted his son to get help as they (his parents) were tired and not getting any sleep. He also reported that Mr Cauchi had been up in the middle of the night, screaming and slamming doors.⁶⁶⁶ Mr Cauchi Snr said that he did not want Mr Cauchi to end up homeless, so they had allowed him to move back into the house with possession of the knives initially; however, he realised that that had been a mistake.⁶⁶⁷
- 3.120. S/Cst Porter explained to Mrs Cauchi that the officers did not have the authority to take Mr Cauchi to a hospital for involuntary treatment, but that they would instead speak to him about not engaging in violent and disrespectful behaviour towards his parents.⁶⁶⁸

⁶⁵⁹ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 8.

⁶⁶⁰ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 2.

⁶⁶¹ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p.2.

⁶⁶² Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 4.

⁶⁶³ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at pp. 3, 6.

⁶⁶⁴ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 17.

⁶⁶⁵ Transcript, D5 (Porter): T366.35 – 36 (5 May 2025).

⁶⁶⁶ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter p. 16.

⁶⁶⁷ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 15.

⁶⁶⁸ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at pp. 3, 11.

3.121. S/Cst Porter and S/Cst McDonnell then came together to discuss the matter further. They expressed surprise and concern to one another that, according to the QPS system, Mr Cauchi appeared to hold a weapons licence.⁶⁶⁹ S/Cst McDonnell also stated that Mr Cauchi appeared to be obsessed and fixated with his knives.⁶⁷⁰

3.122. It was recognised that this matter was attended by some complexity. S/Cst McDonnell explained it this way:

*You've got someone that's making a complaint about his knives being stolen. In the same point, he's legally able to possess those knives. There was nothing stopping him from being able to possess those. But then, then you've got the family there that are obviously concerned about his mental health, and then we had to capture and consider everything about domestic violence as well and just ensure everyone was going to safe when we left there...*⁶⁷¹

3.123. S/Cst Porter explained:

*The, the EEA was out, and even as I in my mind went through even the domestic violence stuff that I could potentially enact, that didn't meet that threshold either. And given that mum was asking for help in relation to getting him to see a doctor, the, the best way to go about that I believed at the time was to send that email to our, like mental health unit, because they know a bit more than us as well. They can make contact with the family, make contact with mum, and, and take that a little bit further than what we're going to do in the 40 minutes that we're there talking to these people.*⁶⁷²

3.124. S/Cst McDonnell and S/Cst Porter then explained to Mr Cauchi that his parents were worried about his mental health and that they intended to return the knives to him in the future. Mr Cauchi again said that he wanted his father charged. S/Cst McDonnell told Mr Cauchi he would “*put that through the system*”, however, the officers did not take a formal report from Mr Cauchi. They spoke with him about respecting his parents and being of good behaviour towards them. Mr Cauchi declined any referral to domestic violence support services.⁶⁷³

3.125. Upon their return to Toowoomba Police Station, S/Csts McDonnell and Porter spoke with their shift supervisor, Sergeant Greg Jurd (**Sgt Jurd**). Sgt Jurd was briefed in accordance with QPS procedures and supported the decision of the officers.⁶⁷⁴

3.126. The incident was recorded on QPRIME as “*Domestic Violence other action*”.⁶⁷⁵ The QPS Operations Procedures Manual states that “DV – Other Action” is where an officer determines that a relevant relationship exists, and allegations of domestic and family violence have been made or occurred, but that investigations determine a Domestic Violence Order is not appropriate. The investigating officer may consider that there is

⁶⁶⁹ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 10.

⁶⁷⁰ Exhibit 1, Vol 23, Tab 854 - BWV of Officer Porter, Annexure A – Transcript of BWV footage of Officer Porter at p. 18.

⁶⁷¹ Transcript, D5 (McDonnell): T339.21 – 27 (5 May 2025).

⁶⁷² Transcript, D5 (Porter): T369.8 – 16 (5 May 2025).

⁶⁷³ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure A – Transcript of BWV footage of Officer McDonnell at pp. 20 – 22.

⁶⁷⁴ Exhibit 1, Vol 23, Tab 854A, Statement of Senior Constable Matthew McDonnell at [25].

⁶⁷⁵ Exhibit 1, Vol 23, Tab 853, QPRIME Occurrence Report, QP2300044964.

insufficient evidence, and a protection order is not necessary nor desirable to protect the aggrieved.⁶⁷⁶

3.127. The incident details are recorded on QPRIME as follows:

*A DV application is not necessary or desirable at this time as the current issue is in relation to mental health rather than ongoing DV. The respondent has been made aware of DV and what constitutes DV, further police do not believe any persons at the address are likely to commit further acts of DV in the future. The respondent is not trying to exert power and control over the aggrieved and witness rather he is suffering with a break from reality. The respondent is seeing someone tomorrow and alternate accommodation for the respondent is being explored with a family friend who also works with troubled youth here in Toowoomba. The family are taking positive steps to help the respondent and getting onto the respondent's previous doctor, a DV application would not be supported by the family and is likely to be more of a hindrance than a help to the family at this time. No property damage, no threats, no coercive control, no previous incidents, no fear, not supported by the family.*⁶⁷⁷

S/Cst McDonnell's referral to the MHIC

3.128. On 8 January 2023, S/Cst McDonnell sent an email to Senior Constable Peter McDiarmid (**S/Cst McDiarmid**), who was relieving in the role of MHIC, Darling Downs Police District, requesting follow up be made with the Cauchi family and Toowoomba Mental Health. The email was copied to Sgt Morris, the substantive MHIC, who was on leave at the time. The email stated:

Just looking for some assistance in relation to a DV job we attended last night. The incident involved a Joel CAUCHI and his father Andrew CAUCHI. Both persons have limited dealings with Police however Joel is flagged as having schizophrenia. Joel contacted police wanting to report his dad for stealing his collective knives.

When we spoke with Joel's mother it was clear that Joel has had a decline in his mental health. Joel was previously medicated for his schizophrenia and was very high functioning and was highly educated studying in Brisbane. His doctors were slowly lowering the dose to the point he is not taking any medication at all now.

Joel moved back to live with his mum and dad a year ago and recently he has been waking up at 3am in the morning walking around the house banging on walls. The father was concerned how he was behaving and have removed the large knives in case he tried to arm himself or them. When the father explained to Joel he removed the knives he became fixated on them and believed that he would be financially broke as a result and would be homeless. When Police tried to explain to Joel that they were removed from him for everyone's safety he was adamant that they were gone for good and that he would have to replace them. Joel could not articulate why they would have to be replaced and wanted his father charged for stealing.

⁶⁷⁶ Exhibit 1, Vol 22, Tab 819, Statement of Acting Assistant Commissioner Roger Lowe at [91].

⁶⁷⁷ Exhibit 1, Vol 23, Tab 853, QPRIME Occurrence Report, QP2300044964 at pp. 12 – 13.

If this is the start of Joel's decline in mental health its likely we will have further calls for service to the house. If a follow up could be made with the family and Toowoomba mental health that would be great.

*Please refer to the DV other report for a dv report.*⁶⁷⁸

- 3.129. No action was taken in response to S/Cst McDonnell's email. The management of S/Cst McDonnell's email is discussed further below.
- 3.130. Insp Quinlan told the Court that he considered that *"the sending of the email was an appropriate means of follow up to ensure there was a connect between police and mental health support systems."*⁶⁷⁹

Consideration of an EEA by S/Cst McDonnell and S/Cst Porter

- 3.131. S/Cst McDonnell gave evidence that he held concerns about the deterioration of Mr Cauchi's mental health.⁶⁸⁰ However, he did not consider that Mr Cauchi was in need of an immediate assessment.⁶⁸¹
- 3.132. While Mr Cauchi was exhibiting signs of a mental illness, which was evident from his fixation on the knives and his inability to explain it, he did not consider that Mr Cauchi was a threat to himself or anyone else at that time.⁶⁸²
- 3.133. S/Cst McDonnell explained his understanding of the threshold for an EEA as follows:

*It needs to be an imminent or an immediate risk to the person's self. For example, that they're intending, or they are trying, to commit suicide. And it needs to be as a result of a major disturbance to a person's mind. So that can be from a disability, an illness, or other reasons for it.*⁶⁸³

- 3.134. With respect to Mr Cauchi, there was nothing to demonstrate that he was a threat to himself, and no suggestion that he was suicidal. In S/Cst McDonnell's view, Mr Cauchi did not fit the criteria for an EEA that night.⁶⁸⁴
- 3.135. S/Cst McDonnell said that the fact that risk to others does not form part of the criteria for an EEA restricts police officers when dealing with people with mental health, and that if the legislation were amended to include risk to others, this would provide police with more clarity.⁶⁸⁵ S/Cst Porter agreed that it would be helpful to police if s 157B of the *Public Health Act* was amended to include harm to others.⁶⁸⁶

⁶⁷⁸ Exhibit 1, Vol 23, Tab 855, BWV of Officer McDonnell, Annexure B – Email by Officer McDonnell, 8 January 2023 at p. 24.

⁶⁷⁹ Transcript, D6 (Quinlan): T432.29 – 31 (6 May 2025).

⁶⁸⁰ Transcript, D5 (McDonnell): T342.10 – 13 (5 May 2025).

⁶⁸¹ Exhibit 1, Vol 23, Tab 854A, Statement of Senior Constable Matthew McDonnell at [29].

⁶⁸² Transcript, D5 (McDonnell): T340.5 – 9 (5 May 2025).

⁶⁸³ Transcript, D5 (McDonnell): T342.29 – 33 (5 May 2025).

⁶⁸⁴ Transcript, D5 (McDonnell): T343.15 – 18 (5 May 2025).

⁶⁸⁵ Transcript, D5 (McDonnell): T342.50 – T.343.7 (5 May 2025).

⁶⁸⁶ Transcript, D5 (Porter): T362.45 – 48 (5 May 2025).

- 3.136. S/Cst Porter explained her understanding of her powers as they relate to an EEA as follows:

The powers that are given to me in relation to the EEAs is when someone's, you know, suffering from a mental health crisis right then and there, and without my intervention would lead to them either dying or potentially hurting themselves really severely ... I just know that if someone's going to hurt themselves, or kill themselves, I need to stop them from doing that. And I stop them by taking them to the hospital so that they can speak to a professional.⁶⁸⁷

- 3.137. S/Cst Porter stated that she considered obtaining an EEA in relation to Mr Cauchi, but "determined there were insufficient grounds" to detain him.⁶⁸⁸ She gave the following evidence when questioned by Counsel Assisting:

Q. Did you give consideration to an emergency examination authority?

A. I did. I did consider it.

Q. Did you discuss that with your colleague, [S/Cst McDonnell]?

A. I believe we did touch on it, but at no point did he ever make any accusations that he was going to hurt himself, and then when I clarified with mum, "Has he made any, any threats, you know, that he's not being honest with us, you know, potentially", even she had said he never once said that he would hurt himself.

Q. When you're considering your emergency examination authority under the Public Health Act, you're very much considering whether or not Joel presents as a risk to himself, not to other people?

A. Yes.

Q. That's because of the way the legislation is worded. Is that right?

A. Yes.⁶⁸⁹

- 3.138. Sgt Morris gave evidence that she thought there may have been sufficient grounds for an EEA, but in forming that view, she relied upon her knowledge and skill set as a MHIC, which is different from that of general duties officers.⁶⁹⁰ Sgt Morris told the Court:

In my capacity with my expanded knowledge base beyond general duties officers due to my exposure of dealing with clinicians for 13 years, there would have been a possibility to expand on serious harm beyond harm to self, to collateral harm. There may have been an opportunity for an emergency examination authority, based on my skill set.⁶⁹¹

⁶⁸⁷ Transcript, D5 (Porter): T361.11 – 26 (5 May 2025).

⁶⁸⁸ Exhibit 1, Vol 23, Tab 853A, Statement of Senior Constable Hope Porter at [15].

⁶⁸⁹ Transcript, D5 (Porter): T368.1 – 17 (5 May 2025).

⁶⁹⁰ Transcript, D6 (Morris): T409.9 – 13 (6 May 2025).

⁶⁹¹ Transcript, D6 (Morris): T408.33 – 36 (6 May 2025).

3.139. "Collateral harm" may include harm that may result unintentionally, financial harm, and reputational harm. It was Sgt Morris' understanding that this concept was applied by clinicians.⁶⁹²

3.140. In relation to collateral harm, it was, in Sgt Morris' view, open to consider such harm when applying the test in s 157B. However, Sgt Morris noted that this was not entirely clear from the language of the provision itself, and said that she understood why officers read the legislation in a narrower way, focusing on threats to suicide or other acts of self-harm.⁶⁹³ Sgt Morris also noted that the issue of the imminency of any harm may have been a "sticking point".⁶⁹⁴

3.141. Insp Quinlan's evidence on a possible EEA was as follows:

*In light of all that information, I'm still supportive of the decision taken by the police at the time with their knowledge and their understanding, and just with how that legislation is. It doesn't allow much – how could I say – you can't defer from that – the actual specific wording of the legislation, too much. And the presentation of, of Joel at the time was as such that their actions at that – on that day at that time were reasonable. In hindsight, with my level of understanding of mental health systems and behaviours, and in hindsight, the nature of the dangerous weapon, there's no ifs, buts or maybes about it. It was – a KA-BAR is a dangerous weapon.*⁶⁹⁵

3.142. Further:

*Again, not being present at the time with the information, with the behaviour demonstrated and things, and noting also too that Joel was intelligent, and you could see his thought processes. He was very measured and calculating, if I may say, in the responses he was providing. So again, I'm still supportive of the decision made by police. Again, I wasn't there at the time, but in hindsight and with the information that's now present, I may have pursued a different action.*⁶⁹⁶

3.143. Insp Quinlan observed that: S/Cst McDonnell and S/Cst Porter actively attempted to utilise their de-escalation training and to establish rapport with all in attendance; any interaction with police sets a precedent of police actions in the future, including in relation to the use of force; and, police are in a limited position to discern clinical information.⁶⁹⁷

3.144. A/DC Kelly said the following in relation to s 157B:

I think it does create confusion for our police ... The threshold is very high in terms of, you know, imminent risk and trying to determine what is imminent risk. So the behaviours may indicate a concern, and secondly, the need for immediate medical examination. I think that threshold is very high. The other complexities for police is that

⁶⁹² Transcript, D6 (Morris): T409.23 - 28 (6 May 2025).

⁶⁹³ Transcript, D6 (Morris): T409.23 - 28 (6 May 2025).

⁶⁹⁴ Transcript, D6 (Morris): T409.20 (6 May 2025).

⁶⁹⁵ Transcript, D6 (Quinlan): T430.10 - 18 (6 May 2025).

⁶⁹⁶ Transcript, D6 (Quinlan): T430.46 - T431.2 (6 May 2025).

⁶⁹⁷ Transcript, D6 (Quinlan): T453 - 468 (6 May 2025).

*they're not clinicians and also trying to understand the level of the disruption to the mental capacity I think is also difficult.*⁶⁹⁸

- 3.145. Insp Quinlan agreed that the removal of the words “or others” from s 157B has created confusion and concern amongst officers. He told the Court:

*... I have seen and received emails from the State Mental Health Team, which is the unit I now oversee. I've seen emails come out raising the concern amongst a network of Mental Health Intervention Coordinators across the State, highlighting and bringing it to their attention that the “and others” provision no longer exists.*⁶⁹⁹

- 3.146. Insp Quinlan continued:

... the law needs to be interpreted, but we're given very narrow scope to be able to interpret that. If the example provided is a person threatening to commit suicide, well that then sets, basically, a, a principle of that is when police are to intervene.

*So from my operational experience itself, it's normally – the normal time that we will execute the detention powers of section 157 more broadly is if a person is actually attempting to take their own life; if they are standing on the edge of a building; if they are climbing onto structures; if they have committed self-harm. That is generally when we will use the provisions in 157B to detain a person.*⁷⁰⁰

- 3.147. Insp Quinlan suggested that the language of s 157B should be amended in three ways:

- (a) To refer to immediate risk of serious harm to others, rather than only referring to immediate risk of serious harm to self;
- (b) To expand on the example cited in the provision so that it does not only include a person threatening suicide; and
- (c) Defining what constitutes “significant” harm.

- 3.148. I take Insp Quinlan's reference to significant harm to mean “serious harm”. A definition of “serious harm” would be beneficial.

- 3.149. Sgt Morris agreed that s 157B should be amended to remove the ambiguity around the nature of the harm that can be considered by police and to “*perhaps give a better scope of what unintentional harm or what serious harm is beyond physical harm to self*”.⁷⁰¹

- 3.150. In the opinion of Professor Nielssen, the interaction on 8 January 2023 was an opportunity to assist or divert Mr Cauchi to treatment. He opined:

Based on the information available to the police at that time, including Mr Cauchi's presentation, his fixation with knives, and what seemed to be the delusional belief that he was in danger and needed that type of knife to protect himself, I believe Mr Cauchi

⁶⁹⁸ Transcript, D20 (Kelly): T1794.30 – 36 (28 May 2025).

⁶⁹⁹ Transcript, D6 (Quinlan): T455.16 – 22 (6 May 2025).

⁷⁰⁰ Transcript, D6 (Quinlan): T419.22 – 32 (6 May 2025).

⁷⁰¹ Transcript, D6 (Morris): T409.30 – 41 (6 May 2025).

*should have been taken to hospital for a mental health assessment and admission to resume treatment.*⁷⁰²

- 3.151. However, Professor Nielssen's evidence was that there was some significant ambiguity in relation to the immediacy of any threat to Mr Cauchi's safety.⁷⁰³
- 3.152. Professor Nordentoft opined that his interaction, coupled with further contact with the QPS on 25 February 2023 in relation to the knives, "*are very clear evidence of Mr Cauchi having a relapse of a psychotic condition.*"⁷⁰⁴
- 3.153. Professor Heffernan stated that this interaction was potentially an opportunity for an EEA. However, he noted that:

*... framing of the risk criteria for an EEA, requiring a belief of immediate risk of serious harm to the person and a belief that an urgent examination is required, may have impacted the police perception that an EEA could be made. There were some indications from [Mr Cauchi] and his parents that the situation would not escalate overnight and also that [Mr Cauchi] had some other opportunities for assistance the following day. This may have influenced the view about the necessary criteria being fulfilled to undertake the EEA. Again, contact with the PCC MHLS could have assisted this situation.*⁷⁰⁵

- 3.154. S/Cst McDonnell was aware of the PCC MHLS but did not consider calling them on that occasion as they knew Mr Cauchi was in a safe place and there was no indication that he was a risk to himself.⁷⁰⁶
- 3.155. Insp Quinlan agreed with Professor Heffernan's assessment in relation to the EEA and said it was possible that contact with the PCC MHLS could have assisted the officers.⁷⁰⁷

Submissions regarding consideration of an EEA

- 3.156. Counsel Assisting did not submit that S/Cst McDonnell and S/Cst Porter should be criticised for failing to detain and transport Mr Cauchi under an EEA.
- 3.157. Counsel Assisting submitted that I could direct a recommendation to Queensland Health in relation to an amendment to s 157B of the *Public Health Act*. I will return to this issue below.
- 3.158. Mr Gnech, legal representative for S/Cst McDonnell and S/Cst Porter, submitted that no adverse comment should be made concerning the conduct of the officers. He submitted that neither officer rushed the situation on 8 January 2023, and that both officers considered their options and made an informed decision.

⁷⁰² Exhibit 1, Expert Volume, Tab 10, Report of Professor Olav Nielssen at [139].

⁷⁰³ Transcript, D16 (Nielssen): T109.38 – 39 (22 May 2025).

⁷⁰⁴ Exhibit 1, Expert Volume, Tab 14, Report of Professor Merete Nordentoft at [59].

⁷⁰⁵ Exhibit 1, Expert Volume, Tab 8, Report of Professor Edward Heffernan at [7.4.3].

⁷⁰⁶ Transcript, D5 (McDonnell): T344.12 – 19 (5 May 2025).

⁷⁰⁷ Transcript, D6 (Quinlan): T433.12 – 41 (6 May 2025).

- 3.159. Mr Gnech submitted that policing is dynamic and that no two situations are the same. Officers may exercise their discretion differently, and this is an inherent aspect of policing. Mr Gnech submitted that the conduct of both officers was measured and professional.
- 3.160. Counsel for the Commissioner, QPS, submitted that S/Cst McDonnell and S/Cst Porter acted appropriately on 8 January 2023 and that the body-worn camera footage illustrates that the officers sought to obtain informed situational awareness and came together to consider the most appropriate response.
- 3.161. Counsel for the Commissioner, QPS, submitted that it was open to the officers to consider that an EEA was not a power available to them on the presentation of Mr Cauchi. It is submitted that it is speculative to suggest that had Mr Cauchi been transported for assessment, he could have restarted medication, and his symptoms most likely would have been brought under control. Counsel submits that Mr Cauchi had never shown any indication of wishing to restart his medication.
- 3.162. Counsel for the Commissioner, QPS, submitted that it was reasonable for the officers to have assessed the situation in the way they did and that Mr Cauchi was not exhibiting behaviours consistent with him posing an immediate risk to himself or others. He was calm, non-threatening, and without access to the knives. His parents did not press the officers to take him to hospital.
- 3.163. It was further submitted that there has been a “*move towards community-based care with that a focus on least restrictive practice*” following the introduction of the *Mental Health Act 2016* (QLD). The human rights of an individual experiencing symptoms of a mental illness are to be balanced against the protection of the community, and this is an important consideration of police when determining whether to exercise powers within this framework.
- 3.164. It is submitted that while it was open to the responding officers to contact the PCC MHLS, they should not be criticised for failing to do this.

Findings

- 3.165. I accept that S/Cst McDonnell and S/Cst Porter should not be criticised for failing to detain and transport Mr Cauchi for an EEA on 8 January 2023. Their actions were reasonable, particularly given the terms of the legislation to which the officers were required to have regard when considering whether to exercise their powers that day. Section 157B of the *Public Health Act* provides that an EEA can only be enacted if there is, relevantly, an immediate risk of serious harm to the person *themselves*. Whether there is an immediate risk of serious harm to another person is not a matter which can be taken into account.
- 3.166. I recognise that, as the Commissioner of QPS submitted, QPS officers are required to make decisions in the context of a framework that recognises the principle of least

restrictive care and also one which reflects the Human Rights legislation in effect in Queensland.

- 3.167. I accept also, 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.
- 3.168. I note the evidence given by S/Cst McDonnell and S/Cst Porter, along with the evidence of Insp Quinlan and A/DC Kelly in relation to the challenges for QPS raised by the present formulation of s 157B. Counsel Assisting have proposed a recommendation in relation to an amendment to s 157B, and I will consider that at the end of this Part.

Consideration of issue of domestic violence by S/Cst McDonnell and S/Cst Porter

- 3.169. As set out above, S/Cst McDonnell and S/Cst Porter were informed by Mrs Cauchi that Mr Cauchi had pushed his parents.
- 3.170. In relation to the management of the domestic violence aspect of this interaction, S/Cst McDonnell gave evidence that he and S/Cst Porter did not believe a Domestic Violence order was necessary and desirable at that time. He stated:

When reviewing the Queensland Police System, this was the first recorded incident between the family. Cauchi had no criminal history, no history of violence and no recorded DV history with other parties. This was the same for Andrew Cauchi and Michele Cauchi (his parents).

This appeared to be a one of [sic] incident with no pattern of behaviour identified. The only risk factor established was the mental health for Cauchi.

Neither part was supportive of domestic violence order and we did not believe any person was at risk of continued Domestic Violence. A Domestic Violence other occurrence was recorded so if future incidents did arise then this occurrence could be taken into consideration.⁷⁰⁸

- 3.171. S/Cst McDonnell further explained:

... it was a tricky situation, but as I said, the parents were happy that they remained there. We knew that the knives were no longer at that location as well. You know, speaking to Joel, he wasn't showing any signs of aggression or made any violent threats to hurt anybody. I was satisfied that, you know – and he said that he was just going straight to bed. He did need to sleep as well. I was satisfied that nobody's safety was in jeopardy by the time I left.⁷⁰⁹

- 3.172. S/Cst Porter stated that she considered a Domestic Violence Order but deemed it inappropriate. She said that Mrs Cauchi and Mr Cauchi Snr were not fearful of Mr Cauchi, there was no domestic violence history, and no threats of actual violence were made.

⁷⁰⁸ Exhibit 1, Vol 23, Tab 854A, Statement of Senior Constable Matthew McDonnell at [26]-[28].

⁷⁰⁹ Transcript, D5 (McDonnell): T341.28 – 33 (5 May 2025).

The “Other Action” report would document the behaviour pattern should there be any future escalation.⁷¹⁰

3.173. S/Cst Porter explained her thinking as follows:

... based on the information that I was given and the fact that he had laid hands on his parents and that he was, mum describes, in a rage, I determined that we needed to put on a domestic violence occurrence. In Queensland we call it “another action”, whereas we recognise at that time that the aspects of domestic violence have occurred and, while it was out of character, like mum was saying it was out of character, it wasn’t to the extent that I could determine that domestic violence had occurred previously. It was occurring now and it would occur in the future.

So it didn’t meet the threshold where we would take out – like we would detain him there, take him back to the station and take an order out against him because that would also be counterproductive based on his mental health. So we determined that we would put the domestic violence occurrence on and that we would also send through an email to our mental health team to make contact with them at a later time to follow up with that because mum was asking for help, and that was the best way that I knew we could get the help she was looking for at the time.⁷¹¹

3.174. On 13 April 2024, following the incident at WBJ, Assistant Commissioner Roger Lowe (**AC Lowe**) directed the QPS Domestic and Family Violence and Vulnerable Persons Command to undertake an external preliminary review of the interaction that occurred on 8 January 2023. The purpose of the review was to undertake an appraisal of the police response as “DV-Other Action”.⁷¹²

3.175. A Briefing Note was prepared by Inspector Melanie Dwyer, which relevantly records the following:

Noting the officers were satisfied domestic violence had been perpetrated and there was a relevant relationship between the parties, the essential element of ‘necessary and desirable to protect the aggrieved’ required deeper consideration in the context of the protective needs of the family, the factors present at that time including violence by the perpetrator and pre-emptive action taken by the aggrieved to ‘hide the weapons’, identification of mental ill-health and (likely) non-compliance with a treatment regime impacting the perpetrator’s behaviour, a PPN could have been issued to provide ongoing protection to the aggrieved and his wife despite the protestations by the aggrieved parties.⁷¹³

3.176. A PPN refers to a Police Protection Notice, which can be issued pursuant to s 101 of the *Domestic and Family Violence Protection Act 2012* (Qld). A PPN may be issued by a police officer if, relevantly, the police officer believes the respondent has committed

⁷¹⁰ Exhibit 1, Vol 23, Tab 853A, Statement of Senior Constable Hope Porter at [15].

⁷¹¹ Transcript, D5 (Porter): T367.24 – 40 (5 May 2025).

⁷¹² Exhibit 1, Vol 22, Tab 819, Statement of Acting Assistant Commissioner Roger Lowe at [95]-[96].

⁷¹³ Exhibit 1, Vol 23, Tab 856, State DFVPU Briefing Note at p. 17.

domestic violence, and reasonably believes the respondent should not be taken into custody.

Submissions – consideration of domestic violence by S/Cst McDonnell and S/Cst Porter

- 3.177. Counsel Assisting submit that whilst the reflection of the QPS is welcome, S/Cst McDonnell and S/Cst Porter should not be criticised for not taking out a PPN. This was a complex scenario given: Mr Cauchi's parents did not report being fearful of him; he presented as calm and cooperative; and he was obviously suffering from a mental health-related issue.
- 3.178. As noted above, Mr Gnech submits that no adverse comment should be made regarding the actions of S/Cst McDonnell and S/Cst Porter.
- 3.179. Further, as previously stated, Counsel for the Commissioner, QPS, submit that the officers' actions on 8 January 2023 were appropriate.

Findings – consideration of domestic violence by S/Cst McDonnell and S/Cst Porter

- 3.180. I accept Counsel Assisting's submission that S/Cst McDonnell and S/Cst Porter should not be criticised for not taking out a PPN, noting the complexity of the scenario they were faced with.
- 3.181. I commend the QPS for their proactive reflection.

Management of S/Cst McDonnell's email request for follow-up

- 3.182. As set out above, S/Cst McDiarmid was relieving for Sgt Morris in the role of MHIC, Darling Downs Police District, on 8 January 2023.
- 3.183. S/Cst McDiarmid had not received any special training prior to relieving in that role. He was provided a verbal handover and a sheet outlining the tasks he needed to complete.⁷¹⁴
- 3.184. S/Cst McDiarmid stated that he viewed S/Cst McDonnell's email and then "*inadvertently overlooked*" making the requested contact.⁷¹⁵ He told the Court:

I recall reading it. I do recall opening the occurrence and reading the content of that email, of the occurrence and familiarising myself with it. I do recall noting to myself that I need to call mum later, being that it was 7 o'clock in the morning. I generally make phone calls after 9 o'clock, at a reasonable hour ...

Unfortunately, there was an oversight, and I did not manage to follow-up. I've continued with my other auditing and tasks through that day. I've then had to familiarise myself

⁷¹⁴ Transcript, D5 (McDiarmid), T381.41 – 45 (5 May 2025).

⁷¹⁵ Exhibit 1, Vol 23, Tab 855B, Statement of Senior Constable Peter McDiarmid at [6]-[9].

*with the examination authorities and I've conducted an interview with the person in their home throughout the rest of the day and didn't manage to call – make that call later in the day.*⁷¹⁶

- 3.185. At the time S/Cst McDiarmid was relieving in the role of MHIC, there was no system in place to flag matters for follow up in the event they were not actioned the day they were received.⁷¹⁷
- 3.186. S/Cst McDiarmid said that had he actioned the email, he would have done so by contacting Mrs Cauchi and his MHIC counterpart at Queensland Health.⁷¹⁸
- 3.187. Sgt Morris stated that the following were available to the MHIC upon receipt of the email from S/Cst McDonnell:
- (a) Inquiries could be made of the Queensland Health MHIC to determine whether Mr Cauchi was currently the client of a mental health service. If so, the concerns of Mr Cauchi's parents could be shared with his treatment team.
 - (b) Mr Cauchi could be contacted directly to discuss whether he would voluntarily engage in treatment.
 - (c) Mr Cauchi's parents could have been contacted to discuss their current knowledge of his treating doctor and encourage them to make contact.
 - (d) Discussion could be had with Mr Cauchi's parents about obtaining an EA.
 - (e) A police referral could be offered.⁷¹⁹
- 3.188. With respect to what Sgt Morris would have done upon receipt of the email:

... I would review Joel on QPRIME. I would immediately reach out to my Queensland Health Mental Health Intervention Coordinator counterpart and we would discuss what history Queensland Health has with him, and then I would engage with the family. Give them a call, "Would you like to have a phone call? Would you like me to come out and visit you?"

*I would discuss options. I would try to engage with Joel directly and try to get him to attend hospital voluntarily or go to his GP. If he would not attend voluntarily and I had sufficient information for an examination authority, I would have applied for an examination authority.*⁷²⁰

- 3.189. Sgt Morris took no action in relation to the email as it had been sent to S/Cst McDiarmid in her absence, and it was not a matter that was handed over to her when she returned.⁷²¹

⁷¹⁶ Transcript, D5 (McDiarmid): T385.1 – 22 (5 May 2025).

⁷¹⁷ Transcript, D5 (McDiarmid): T386.11 – 13 (5 May 2025).

⁷¹⁸ Transcript, D5 (McDiarmid): T386.42 – 46 (5 May 2025).

⁷¹⁹ Exhibit 1, Vol 23, Tab 855A, Statement of Sergeant Tracy Morris at [7].

⁷²⁰ Transcript, D6 (Morris): T406.5 – 15 (6 May 2025).

⁷²¹ Exhibit 1, Vol 23, Tab 855A, Statement of Sergeant Tracy Morris at [5]-[6].

- 3.190. With respect to the circumstances in which S/Cst McDiarmid came to relieve in her role, Sgt Morris gave evidence that:

... I actually had to solicit ... [S/Cst McDiarmid] to come do my role. I find it really hard to get people to relieve me when I am absent from my role, and right now no-one is doing the job because I am here. A lot of people are fearful of the role and think there's too much risk involved, or they don't have the knowledge base to do that. I, I did approach [S/Cst McDiarmid] to do that role because I knew he had an interest in mental health, and I know him as a really good officer and his oversight on that email is devastating and it is not indicative of him as an officer or how he performed my role.⁷²²

- 3.191. Insp Quinlan described the email overlooked by S/Cst McDiarmid as a “*missed opportunity*.”⁷²³

- 3.192. S/Cst McDiarmid accepted that the interaction on 8 January 2023 was a missed opportunity to plug Mr Cauchi back into the mental health system.⁷²⁴

- 3.193. To the credit of the QPS, they have reformed the process by which matters are referred to a MHIC with a view to minimising the chances of an email inadvertently being overlooked or the subject of an oversight. Whereas previously referrals were sent via email, they are now made the subject of tasks in QPRIME, with the task being assigned for action with follow-up. Further, only supervisors can approve the task being closed.⁷²⁵

- 3.194. Insp Quinlan explained:

We have taken steps to try and put some additional safeguards in place with our amendments to the [Operations Procedural Manual] already in relation to using a tasking process on our QPRIME system so that there is actually a trail that can be managed, supervised and audited. So just to put that additional governance in place around that request, so it's recorded, it's time and date stamped. There's that integrity of process over the provision of the request, and then once the request is made the task needs to be finalised and approved by a supervising officer...

It sits on a work list. Obviously resourcing and timing and things dictates how soon that task will be seen due to other competing priorities or a MHIC's role, but it is actually on a list and can't disappear. It has to be actually started, completed, finalised, with a supervisor check as well.⁷²⁶

- 3.195. The QPS Operations Procedure Manual has been updated to reflect this change in process, and the QPS community culture and engagement have been engaged to publicise and promote the change.

⁷²² Transcript, D6 (Morris): T404.25 – 34 (6 May 2025).

⁷²³ Transcript, D6 (Quinlan): T432.31 – 32 (6 May 2025).

⁷²⁴ Transcript, D5 (McDiarmid): T388.7 – 9 (5 May 2025).

⁷²⁵ Exhibit 1, Vol 45, Tab 1602C, Statement of A/Deputy Commissioner Mark Kelly at [112]-[113].

⁷²⁶ Transcript, D6 (Quinlan): T432.34 – 49 (6 May 2025).

Submissions – the management of S/Cst McDonnell's email

- 3.196. Counsel Assisting submit that the Court would welcome the way in which the QPS have addressed an obvious shortcoming in the tasking process.
- 3.197. Counsel Assisting submit that the other shortcoming is with respect to resourcing. S/Cst McDiarmid was under significant pressure in the MHIC role and had limited training. Counsel Assisting submit that the evidence is that S/Cst McDiarmid was otherwise a diligent officer who performed the role to a high standard.
- 3.198. Mr Gnech, legal representative for S/Cst McDiarmid, submitted that the evidence demonstrates that S/Cst McDiarmid is a competent, committed, and responsible police officer who overlooked a single email amidst a significant workload and limited resources. It is submitted that, as has been the case throughout the proceedings, sympathy should continue to be demonstrated towards S/Cst McDiarmid and the situation he now finds himself in. In the current era of overwhelming email traffic, it is not uncommon for even diligent professionals to inadvertently miss or fail to return an email. This should not be viewed as a reflection on his professionalism, competence, or commitment.
- 3.199. Counsel for the Commissioner, QPS, submit that, as was acknowledged by several witnesses, the failure to follow up on the email was a missed opportunity to attempt to plug Mr Cauchi back into the mental health system, and it is not appropriate to be more critical than this.
- 3.200. Counsel submits that this is an example of a mistake that can take place in the context of a system that is not working as efficiently as it needs to be designed to work, and one that occurred in the context of there being a considerable amount of stress on the system at that time.
- 3.201. Counsel submits that the system has been changed so that this could not happen again. The process now is that QPRIME does not allow there to be non-responsiveness, and there are follow-ups and reminders, which means that if something does fall through the cracks, it would not fall through the system.

Findings – management of S/Cst McDonnell's email

- 3.202. 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 in this regard.
- 3.203. I accept the submission that evidence before me establishes that S/Cst McDiarmid is a competent, committed, and responsible police officer who overlooked a single email amidst a significant workload and limited resources.
- 3.204. I acknowledge that this Inquest must have been a very difficult experience for S/Cst McDiarmid and trust that he understands that what occurred has been considered in

context, and his action in overlooking the email does not appear to be a reflection on his professionalism, competence, and commitment.

- 3.205. I acknowledge also the changes that have been made in relation to the use of QPRIME to overcome the risk of a task being overlooked in the future.

E. Recommendations

- 3.206. Counsel Assisting has proposed three recommendations in relation to the evidence examined in this Part.
- 3.207. The first concerns reform of s 157B of the *Public Health Act 2005* (Qld).
- 3.208. The recommendation proposed by Counsel Assisting is directed to Queensland Health in the following terms:
- That Queensland Health consider an amendment to s 157B of the Public Health Act in line with the comments in Part 3 [of Counsel Assisting's submissions]
- 3.209. That is, the provision should be amended in accordance with the evidence of Insp Quinlan:
- (a) To refer to immediate risk of serious harm to others, rather than only referring to immediate risk of serious harm to self;
 - (b) To expand on the example cited in the provision so that it does not only include a person threatening suicide; and
 - (c) To define what constitutes serious harm.
- 3.210. Counsel for the Commissioner, QPS, endorses the proposed recommendation. Counsel submits that the evidence before me is consistent that an amendment to section 157B is necessary and that the Commissioner concurs with the proposal that it be looked at by an appropriate body. Counsel for the Commissioner submitted that s 157B is a provision that, in the public interest, needs to be reformed as soon as possible.
- 3.211. Queensland Health did not make submissions in relation to the proposed recommendation.
- 3.212. Mr Gnech, legal representative for the four individual QPS Officers, supported the proposed recommendation.
- 3.213. Having regard to the evidence before me, I am satisfied that it is necessary and desirable for there to be consideration of an amendment to s 157B in accordance with the three aspects identified by Insp Quinlan in his evidence. I note that the Commissioner of QPS endorses the proposed recommendation.

RECOMMENDATION

Recommendation 9: To Queensland Health

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.

3.214. The second recommendation Counsel Assisting propose that I make concerns the resourcing of the MHICs.

3.215. Counsel Assisting submits that it is essential that employers, including the QPS, properly resource systems so that individual officers are not crushed by their workload or left to feel personally responsible when the systems they work in are overloaded.

3.216. Counsel Assisting submits that their proposed recommendation will support the very worthwhile work of the MHICs and make it less likely that members of the public, such as Mr Cauchi, fall through the gaps.

3.217. The recommendation proposed by Counsel Assisting is directed to the QPS and is in the following terms:

That the QPS give consideration to better resourcing of the MHIC to meet the increasing demand on the Queensland Police to respond to mental health incidents. The recommendation should be directed to:

- (a) an evaluation of the service needs for the MHICs in each region; and
- (b) increasing the staff in the Darling Downs Region, an area of recognised need.

3.218. During oral submissions, Counsel for the Commissioner, QPS, provided an update regarding MHIC resourcing. Counsel advised that in relation to all 15 Queensland police districts, full-time dedicated MHICs are now in place or, alternatively, have had a dedicated MHIC position created and gazetted.⁷²⁷

3.219. Accordingly, the Commissioner, QPS, submitted that no recommendation is required, as consideration has been given to this issue and resources are improving. However, Counsel for the Commissioner, QPS, submitted that, in terms of resourcing more generally, if I were minded to encourage the government to resource police better so that there are additional police and clinicians available to respond to the escalating number of mental health incidents, that would be welcome.

⁷²⁷ Transcript, Closing Submissions D1: T1945.12-17 (25 November 2025).

- 3.220. Mr Gnech submitted in support of this recommendation and submitted that it arose from compelling evidence that the mental health space for police is grossly under-resourced in Queensland.
- 3.221. I acknowledge that the QPS now has a dedicated full-time MHIC position either filled or created for each Queensland Police District. However, I consider that there is still a need to evaluate the need for resourcing of MHICs in each region. It may be that more than one MHIC in each region is required. There is already evidence before the Court of the need for greater MHIC resources in the Darling Downs region, and Sgt Morris' evidence to that effect was accepted by Insp Quinlan.
- 3.222. Accordingly, I consider it necessary and desirable for the Commissioner of QPS to evaluate the need for MHICs in each region and to give consideration to increasing the staffing of MHICs in the Darling Downs region.

RECOMMENDATION

Recommendation 10: To the Commissioner of the Queensland Police Service

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.

- 3.223. The third proposed recommendation of Counsel Assisting concerns the PCC MHLS and its potential adoption, or the adoption of a similar service, in NSW.
- 3.224. As set out above, this service has been available in Queensland since January 2015. That service is frequently used by officers of the QPS. In 2024, there were 5,758 clinical interventions through the PCC MHLS. The Commissioner, QPS, submits that anecdotally, police officers who have used the PCC MHLS have provided positive feedback about the service.
- 3.225. I note that the Productivity Commission, in its 2018 report, relevantly recommended that, as a priority, mental health professionals should be embedded in police communication centres.⁷²⁸

⁷²⁸ Exhibit 1, Electronic Material, Item 71, Productivity Commission Report at p. 1012.

- 3.226. Counsel Assisting proposed the following recommendation directed to the NSWPF and NSW Health:

As part of the package of reforms currently being considered, NSWPF and NSW Health, establish a real-time 24/7 mental health information sharing and advice service that is not geographically bound, which would:

- (a) support police responses and decisions about care;
- (b) provide real-time mental health support to police during a crisis response; and,
- (c) assist to coordinate follow-up, where appropriate.

Consideration should be given to the Queensland model of a Police Communications Centre Mental Health Service (PCC MHLS) and/or mental health clinicians in police communications (000) call centres.

- 3.227. Counsel for the Commissioner, NSWPF, do not object to the recommendation, but note the limitations to the effectiveness of such a model in NSW. In relation to those limitations, Supt Hales gave evidence that the lack of any central database to, relevantly, access mental health records within NSW Health which is likely to significantly limit the ability of any clinicians embedded in the PCC.⁷²⁹
- 3.228. Counsel for NSW Health submitted that this recommendation is unnecessary for the following reasons: there is presently a Cabinet process to consider co-responder models (which I understand from NSWPF and NSW Health is to incorporate a PCC MHLS like service) for broader adoption; it is a matter for Cabinet which models are adopted as part of that process; and, that although the evidence in the Inquest touched upon different models, it did not comprise a thorough examination of all options, their respective feasibility and viability across the State, nor their cost-efficiency. Nor was it possible to discuss the different models with the various stakeholders.
- 3.229. The joint position of NSWPF and NSW Health is that the recommendation should be framed in the following terms:
- 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.
- 3.230. I understand that a process is underway whereby options to assist NSWPF officers to deal with people with mental health issues, such as options for co-responder models involving both NSWPF and NSW Health, are being considered. This includes consideration of a PCC MHLS-like service.
- 3.231. I note the joint position of NSWPF and NSW Health presented to me during oral submissions, and I propose to make the recommendation in those terms.

⁷²⁹ Exhibit 1, Tab 50, Statement of Superintendent Kirsty Hales at [53].

RECOMMENDATION

Recommendation 11: To the NSW Government

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.

F. Mr Cauchi's weapons related applications to the QPS

- 3.232. Evidence received in this matter demonstrates that in 2021, Mr Cauchi had an interest in joining a pistol shooting club. In Queensland, in order to do this, a "Statement of Eligibility" must be obtained from the QPS. Mr Cauchi obtained a Statement of Eligibility in April 2021. How Mr Cauchi did this, and the process undertaken by the QPS in issuing the Statement of Eligibility, is detailed below.
- 3.233. There is documentary evidence that also indicates that Mr Cauchi had previously applied to the QPS for a weapons licence, in around late 2001. The QPS sent Mr Cauchi's then treating doctors a request for further information in relation to his application.⁷³⁰ However, there is no evidence that Mr Cauchi ever obtained a weapons licence at that time, or at any point thereafter.

Statement of Eligibility

- 3.234. On 25 January 2021, Mr Cauchi applied to the QPS for a Statement of Eligibility to enable him to join a pistol shooting club. As previously stated, at that time, Mr Cauchi was not taking any psychotropic medication nor was he receiving psychiatric treatment on a regular basis.
- 3.235. Section 98B of the *Weapons Act 1990* (Qld) (**the Weapons Act**) provides that it is a condition of an approved pistol club's shooting club permit that a club must not accept a person for membership unless the person's application is accompanied by, relevantly, "*a current statement in the approved form signed by an authorised officer that the person is a fit and proper person to hold a licence*". Statements of Eligibility are issued by the QPS.
- 3.236. A Statement of Eligibility is not a weapons licence and does not permit the purchase of a weapon.⁷³¹
- 3.237. The Weapons Act does not define "fit and proper person" for the purposes of grants of Statements of Eligibility. Authorised QPS officers use the criteria set out in s 10B of the Weapons Act and utilise s 14 to make further enquires and investigations for the purposes of assessing applications.⁷³²
- 3.238. Mr Cauchi made his application at Brisbane City Police Station. Mr Cauchi marked his application form to indicate that he had required treatment for "*psychiatric or emotional problems*."⁷³³ In circumstances where this is disclosed, a doctor's certificate is required to certify that the relevant condition does not affect the applicant's ability to possess or use a firearm. Annexed to Mr Cauchi's application was a copy of a medical certificate

⁷³⁰ Exhibit 1, Vol 17, Tab 783, Toowoomba Base Hospital Medical Records at p. 552.

⁷³¹ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Manager (Operations) Cameron Barwick at [8], [11].

⁷³² Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Manager (Operations) Cameron Barwick at [9].

⁷³³ Exhibit 1, Vol 23, Tab 832, Weapons Act application at p. 2.

issued by Dr Sagir Parkar on 20 January 2021, arising from the consult Mr Cauchi had with Dr Parkar outlined in Part 2 of these findings.

- 3.239. Dr Parkar stated, in the certificate, that, at that time, Mr Cauchi's mental state was stable and that he was "*in remission without any active symptoms of mental illness.*" Further, Mr Cauchi did "*not pose an imminent risk to himself or others*" and was "*not on psychotropic medication and [had] been in remission in the absence of treatment for the past 18 months.*"⁷³⁴
- 3.240. Mr Cauchi's application was the subject of an "autovet" by the QPS on 5 February 2021.⁷³⁵ The vetting assessment recorded a result of "fail" on the basis that Mr Cauchi had a condition on his driver license.⁷³⁶ Such a result does not preclude the application being granted, but may trigger further assessment.⁷³⁷
- 3.241. On 8 February 2021, Mr Cauchi's application was assessed using the QPS Weapons Licensing Risk Assessment Matrix.⁷³⁸ Subsequently, the assessing officer sent a letter to Dr Parkar requesting that he provide a "*firm recommendation*" as to whether he considered Mr Cauchi "*to be a fit and proper person to be issued with a weapons licence authorising the possession and use of firearms, given the need to ensure public and individual safety*" (emphasis in original).⁷³⁹
- 3.242. On 19 February 2021, Dr Parkar responded, stating that he had been informed by Mr Cauchi that his assessment of him was for the purposes of obtaining a medical certificate to be provided to the local gun range where he wished to practice target shooting under supervision. In relation to Mr Cauchi's psychiatric history, Dr Parkar stated:

Joel reports being admitted to a psychiatric unit in Toowoomba at the age of 17 yrs for an episode of psychosis secondary to year-long use of cannabis. He reports experiencing tactile hallucinations at that time and states that he was commenced on Clozapine as part of his treatment. After being on Clozapine for 2 years, his treatment was changed Aripiprazole.

More recently Joel reports seeing Dr Boros-Lavack at Toowoomba privately for monthly follow up sessions until 12 – 18 months ago.

He reports being off Abilify for the past 18 months.

No relapse in psychotic symptoms reported during that time period. This has been corroborated by correspondence from Dr Boros-Lavack's offices.

...

⁷³⁴ Exhibit 1, Vol 23, Tab 832, Weapons Act application at p. 8.

⁷³⁵ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [17].

⁷³⁶ Exhibit 1, Vol 23, Tab 833, Weapons Licensing Autovetting Results, 5 January 2021.

⁷³⁷ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [17].

⁷³⁸ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [18]; Exhibit 1, Vol 23, Tab 834 – Weapons Licensing Risk Assessment Matrix.

⁷³⁹ Exhibit 1, Vol 23, Tab 835, Weapons Licensing Letter to Dr Sagir Parkar, 18 February 2021.

*Currently not on medication.*⁷⁴⁰

3.243. Dr Parkar recorded his impression of Mr Cauchi as follows:

Presents with stable mental state.

No acute psychotic symptoms at this stage.

*His level of risk to himself and others is low.*⁷⁴¹

3.244. Dr Parkar concluded, “[t]herefore in my opinion, Mr Cauchi is fit and proper to be issued with a weapons license at this stage” (emphasis in original).⁷⁴²

3.245. Absent from this letter, and the medical certificate issued on 20 January 2021, is reference to Mr Cauchi’s diagnosis of schizophrenia.

3.246. On 27 March 2021, Mr Cauchi attended Brisbane City Police Station at around 1:24pm, and this attendance was recorded on QPRIME by way of an Intelligence/Street Check which stated:

*Subject person attended City Station stating that he was here to provide his ‘birth’ address to weapons licensing. R/O contacted weapons and spoke with supervisor (Steve) and advised that all they are waiting for is his doctors report. Subject person displayed fixated behaviour and was adamant that he needed to provide his ‘birth’ address R/O is of the belief that CAUCHI is mentally unstable.*⁷⁴³

3.247. Mr Cauchi’s Statement of Eligibility was approved at 2:22pm on 27 April 2021.⁷⁴⁴

3.248. The Statement of Eligibility was again autovetted on 28 April 2021, with a “fail” condition again recorded on the basis of the condition on Mr Cauchi’s driver license.⁷⁴⁵

3.249. A Statement of Eligibility was issued to Mr Cauchi on 28 April 2021 by the QPS.⁷⁴⁶ As indicated above, the Statement of Eligibility was a necessary precondition to enable Mr Cauchi to apply for membership of a pistol shooting club.

3.250. Mr Cauchi’s Statement of Eligibility expired on 28 July 2021.⁷⁴⁷

3.251. Inspector Manager (Operations) Cameron Barwick, Weapons Licencing Group, Operations Support Command, QPS (**Insp Barwick**), who reviewed the assessment of Mr Cauchi’s application, stated that the decision to issue the Statement of Eligibility to Mr Cauchi “was one open to them to make in the context of the information available”,

⁷⁴⁰ Exhibit 1, Vol 23, Tab 836, Medical Report of Dr Sagir Parkar at p. 2.

⁷⁴¹ Exhibit 1, Vol 23, Tab 836, Medical Report of Dr Sagir Parkar at p. 2.

⁷⁴² Exhibit 1, Vol 23, Tab 836, Medical Report of Dr Sagir Parkar at p. 2.

⁷⁴³ Exhibit 1, Vol 23, Tab 837, QPRIME Intelligence Street Check Report Q12100771856 at p. 1.

⁷⁴⁴ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [26].

⁷⁴⁵ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [27].

⁷⁴⁶ Exhibit 1, Vol 23, Tab 839, Weapons Act Statement of Eligibility.

⁷⁴⁷ Exhibit 1, Vol 22, Tab 819, Statement of Acting Assistant Commissioner Roger Lowe at [55].

and that “[i]t is not unreasonable in this context for the decision-maker to place appropriate weight on the opinion of a consultant psychiatrist.”⁷⁴⁸

Conduct of Dr Parkar

- 3.252. Dr Parkar had extensive experience with patients with schizophrenia.⁷⁴⁹ He saw Mr Cauchi on one occasion, and Mr Cauchi indicated that the purpose of the attendance was so that Mr Cauchi could visit a gun range and practice target shooting.
- 3.253. Counsel Assisting submitted that before providing Mr Cauchi with a medical certificate for that purpose, Dr Parkar should have exercised “*extreme caution*”.⁷⁵⁰ They point to the fact that Dr Parkar determined Mr Cauchi had a stable presentation based on a mental state examination over a single appointment and on the basis of what Mr Cauchi disclosed to him, which was accepted at face value. Counsel Assisting further submit that, in any event, what Mr Cauchi did disclose about his long-term history should have alerted Dr Parkar to the need for extreme caution.⁷⁵¹
- 3.254. Dr Parkar was not aware that he could, at that time, access the Queensland Health Provider Profile (**HPP**) to access collateral information about Mr Cauchi. When such collateral information was obtained from the practice of Dr Boros-Lavack, he came to realise that Mr Cauchi had taken Clozapine for 15 years rather than for two (as Mr Cauchi had told him).
- 3.255. As recognised by both Counsel Assisting and Counsel for Dr Parkar in their submissions, Dr Parkar made a number of concessions in relation to what he should have done differently which, taken together, in effect acknowledged he should have exercised greater caution.⁷⁵² These include the following:
- (a) An acceptance that Mr Cauchi was minimising the time he was taking Clozapine was very unusual and a “red flag”.⁷⁵³
 - (b) That the inconsistency between the period of time Mr Cauchi actually took Clozapine and the period of time he told Dr Parkar he took Clozapine should have been noted in the medical certificate he authored.⁷⁵⁴
 - (c) A qualification of the statement that Mr Cauchi had been “*in remission in the absence of treatment for 18 months*” to indicate “[t]oday he appears to be stable and may be in remission. However, I am not his regular treating psychiatrist, and I note he was last seen in March 2020.”⁷⁵⁵

⁷⁴⁸ Exhibit 1, Vol 23, Tab 863D, Statement of Inspector Cameron Barwick at [33]-[34].

⁷⁴⁹ Transcript, D13 (Parkar): T1134.49 – T1135.2 (15 May 2025).

⁷⁵⁰ Written submissions of Counsel Assisting at [778].

⁷⁵¹ Written submissions of Counsel Assisting at [778].

⁷⁵² Written submissions of Counsel Assisting at [782]; Written submissions on behalf of Drs Grundy, Ruge, Parkar and Barkla at [29].

⁷⁵³ Transcript, D13 (Parkar): T1146.19 – 29 (15 May 2025).

⁷⁵⁴ Exhibit 1, Vol 22, Tab 808, Oxford Clinic Medical Records at p. 7.

⁷⁵⁵ Transcript, D13 (Parkar): T1152.8 – 13 (15 May 2025).

(d) That Dr Parkar probably should have stated in the medical certificate that Mr Cauchi indicated to him that he wanted a fitness assessment for the purposes of target shooting at a range, under supervision, once a week or once a fortnight.⁷⁵⁶

3.256. Dr Parkar said he did not, at the time he saw Mr Cauchi, have access to the firearm risk assessment guidelines issued by the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), which were issued in September 2023. The RANZCP guidelines as they relate to firearms risk assessment have been discussed further in Part 2 of these findings.

3.257. Professor Heffernan gave evidence that, as a general rule, he would have “*a high degree of suspicion and concern*” that a firearms licence was not appropriate and that a “*thorough assessment in terms of the appropriateness of that individual to have a licence*” was required.⁷⁵⁷

3.258. Professor Heffernan said that when dealing with a person with treatment resistant schizophrenia “*the risk with weapons and firearms in particular is, is really significant*.”⁷⁵⁸

Findings

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

⁷⁵⁶ Transcript, D13 (Parkar): T1152.15 - 19 (15 May 2025).

⁷⁵⁷ Transcript, D16 (Heffernan): T1467.46-T1468.5 (22 May 2025).

⁷⁵⁸ Transcript, D16 (Heffernan): T1502.11-25 (22 May 2025).

Part 4

**Mr Cauchi's movements in NSW
(2023 to 2024) and his interest in
knives**

Mr Cauchi's movements in NSW (2023 to 2024) and his interest in knives

- 4.1 To address the evidence arising in relation to Mr Cauchi's movements in NSW, including his arrival from Queensland, and relevant evidence preceding the events of 13 April 2024, this Part will be divided into the following sections:

Section A	Introduction
Section B	Mr Cauchi's interactions with NSW government agencies
Section C	Mr Cauchi's interactions with homelessness services
Section D	Mr Cauchi's use of storage facilities
Section E	Mr Cauchi's other interactions in 2024
Section F	Mr Cauchi's interest in and purchases of knives
Section G	Police powers with respect to the possession of knives
Section H	Recommendations

A. Introduction

- 4.2 As set out previously in these findings, Mr Cauchi was born, and resided, in Queensland for most of his life. Noting the events of 13 April 2024, it was necessary for the Inquest to consider the circumstances in which Mr Cauchi arrived in NSW and any relevant evidence regarding his movements following his arrival.
- 4.3 Mr Cauchi had limited interactions with NSW Government agencies. Those interactions are comprised of a single interaction with the NSWPF on 21 July 2023 and one hospital attendance for a matter unrelated to his mental health on 24 August 2023; these interactions are considered in Section B.
- 4.4 Evidence obtained during the coronial investigation revealed that ultimately Mr Cauchi left Queensland on 21 December 2023, arriving in Sydney on 22 December 2023. He made this trip in his vehicle, a silver Toyota Aurion, which he later sold on 25 February 2024.
- 4.5 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. Mr Cauchi did not return to Queensland after 22 December 2023.
- 4.6 The evidence suggests that during Mr Cauchi's time in Sydney, he was homeless and socially isolated. As will be further outlined in Part 6, by 13 April 2024, Mr Cauchi was sleeping rough around the Maroubra Beach Pavilion. While Mr Cauchi engaged with several homelessness services, as outlined below in Section C, there is no evidence he engaged with any mental health services or otherwise sought treatment for his mental health in NSW.
- 4.7 In addition to these interactions, there was evidence that demonstrated that while he was based in NSW, Mr Cauchi relied on the use of storage facilities to keep his belongings. This is considered in Section D.
- 4.8 Importantly, evidence available at Inquest, as set out in Part 2 and Part 3, demonstrated Mr Cauchi's interest in knives. As further outlined in Section F, it is apparent that on 24 February 2024, whilst in NSW, Mr Cauchi purchased the knife used on 13 April 2024, and there was other evidence of his persistent interest in knives following his arrival in NSW.
- 4.9 The totality of the evidence arising in this Part, particularly concerning Mr Cauchi's interest in knives, is considered in the context of a discrete issue that arose with respect to police powers regarding possession of knives. The relevant powers in NSW and Queensland are briefly outlined in Section G, with recommendations arising from this part considered in Section H.

B. Mr Cauchi's interactions with NSW government agencies

- 4.10 Mr Cauchi's interactions with NSW Government agencies were limited. Nevertheless, it is important to consider those interactions noting the events that occurred on 13 April 2024.

Mr Cauchi's interaction with NSWPF on 21 July 2023

- 4.11 Around 1:00am on 21 July 2023, a member of the public, who was walking in the Rocks area in the Sydney CBD, saw a fully zipped up sleeping bag with what looked to be a body inside. Concerned that the person in the sleeping bag may be deceased, police were contacted and two NSWPF officers attended at 1:15am.
- 4.12 The officers woke Mr Cauchi, who was asleep in the sleeping bag. Mr Cauchi told the officers that he was in NSW to go backpacking and produced his Queensland driver licence. Dried blood was observed on Mr Cauchi's sleeping bag.
- 4.13 The NSWPF officers conducted checks in relation to Mr Cauchi through a Mobi-POL, a device enabling the officers to access information held by police about a person's history. This check also enabled officers to access information held by QPS relating to Mr Cauchi. The check revealed that Mr Cauchi had warnings in relation to knives and his mental health, and he was at possible risk of self-harm.
- 4.14 A general search was conducted of Mr Cauchi to check for the presence of knives, with the search recorded on body-worn video. No knives or other items of interest were located. Mr Cauchi had a cutlery set and food in his backpack, which the NSWPF officers considered was reasonable given that he was sleeping rough.
- 4.15 The NSWPF officers noticed a cut on Mr Cauchi's right thumb. Mr Cauchi refused their offer to call an ambulance to treat this injury, and the officers urged Mr Cauchi to attend a hospital to have it looked at.
- 4.16 Mr Cauchi appeared to the officers to be coherent and not a danger to himself or others. No further action was taken.

Mr Cauchi's attendance at hospital on 24 August 2023

- 4.17 On 24 August 2023, Mr Cauchi presented to Royal Prince Alfred Hospital (**RPAH**) in Sydney for medical treatment regarding a complaint that he had blocked ears, which were causing him pain.
- 4.18 During this attendance, Mr Cauchi denied any mental health history and stated that he was homeless. Noting this, there is nothing to suggest that this presented an opportunity to engage with Mr Cauchi regarding his mental health.

Submissions

- 4.19 Regarding the interaction with NSWPF on 21 July 2023, Counsel Assisting submitted that the Court would accept the opinion expressed by Professor Nielssen, who opined that Mr Cauchi's demeanour and behaviour at the time of the welfare check performed by the NSWPF did not raise any concerns about Mr Cauchi's danger to himself or the community of a kind that might have been grounds for mental health referral or involuntary admission.⁷⁵⁹

Findings

- 4.20 I accept the opinion expressed by Professor Nielssen that 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.
- 4.21 I find the actions of the NSWPF officers on 21 July 2023 to be reasonable. They understood Mr Cauchi to be experiencing homelessness, and he told them he was backpacking. 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.

⁷⁵⁹ Written submissions of Counsel Assisting at [481].

C. Mr Cauchi's interactions with homelessness services

- 4.22 During Mr Cauchi's time in NSW, in particular from mid-2023 to April 2024, he had sought the assistance of several homelessness services. There is no evidence that Mr Cauchi sought help to obtain accommodation, and rather, he primarily sought meals and personal items.
- 4.23 A summary of the known attendances at such homelessness services is outlined below.
- 4.24 Mr Cauchi attended a community pantry in Mascot operated by South Eastern Community Connect on three occasions: 13 July 2023, 27 July 2023, and 7 September 2023. He sought items from this service, namely a phone charger and a small fridge, via email. A manager from that service stated that Mr Cauchi did not display any unusual behaviour during their interactions.
- 4.25 Between 31 October 2023 and March 2024, Mr Cauchi requested various items from Newtown Mission via Facebook Messenger. He also attended Newtown Mission (or its Jordan Café in Newtown) on various occasions, with the last occasion being on 11 April 2024. Newtown Mission staff members or volunteers gave evidence regarding their interactions with Mr Cauchi as follows:
- (a) In mid-March 2024, Mr Cauchi attended Newtown Mission to collect a sleeping bag he had requested. Mr Cauchi had a backpack and some sort of pocket knife, which staff described as being *"like a tool that people living on the street would use to open cans and stuff knife [sic] that."* A staff member described Mr Cauchi as being quiet, calm, and polite; *"quite clean cut"* for a person who was homeless; socially awkward, which the staff member believed stemmed from mental health issues (resulting in him being *"sort of odd in the way he spoke"*); and capable of having a transactional conversation.
 - (b) In March 2024, Mr Cauchi attended Newtown Mission to collect beanies he had requested. Another staff member described Mr Cauchi as introverted, reasonably tidy, quite skinny, and she suspected he may use drugs.
 - (c) A senior Newtown Mission Minister saw Mr Cauchi on one or two occasions in late March to early April 2024. He describes Mr Cauchi as follows:

My assessment was yes Joel was homeless, there were clearly some mental health issues, but none that were threatening to anyone else at the time. The nature of his communication both online and verbally was a very odd and direct way of communicating. It was more than just awkwardness. It was as if I was only privy to part of the conversation. We have a lot of people with schizophrenia, so this is quite common or not unusual. But given, all he was asking for was cooking equipment or storage things, nothing appeared particularly unusual. He never asked for any knives and that is not something we would ever give out.

- 4.26 A volunteer saw Mr Cauchi on 4 and 11 April 2024 when he attended for meals. On 4 April 2024, she states he looked “sad” and “*not in a good way*”. On 11 April 2024, Mr Cauchi looked troubled and “*kind of flat*”, was quiet and not threatening, and said, “very earnestly”, “*thank you for being kind to me*”.
- 4.27 In around early March 2024, Mr Cauchi sought assistance from the Addison Road Food Pantry in Marrickville. A staff member at the food pantry described Mr Cauchi as “very appreciative and polite, not aggressive at all. Just a bit twitchy and nervous”.
- 4.28 In addition to interactions with homelessness services, it was established that Mr Cauchi had also relied on the use of storage facilities during his time in NSW.

D. Mr Cauchi's use of storage facilities

- 4.29 From at least October 2023 to April 2024, the evidence established that Mr Cauchi had hired storage spaces at various Kennards Storage facilities (in the Australian Capital Territory, NSW, and Queensland) and stored his belongings there.
- 4.30 Records suggest that Mr Cauchi would lease storage units around 1.5 metres by 1.5 metres in size or smaller. Evidence obtained during the coronial investigation suggests that Mr Cauchi would use such storage units as his "home base" for periods of time.
- 4.31 On two occasions in October 2023, Mr Cauchi was sent warnings by Kennards staff via email, including in relation to spending an excessive amount of time on site and leaving his belongings outside of his storage unit. Alerts concerning Mr Cauchi were also placed on the Kennards system to notify staff that Mr Cauchi had potentially been sleeping on site.

Kennards Waterloo

- 4.32 From 31 January 2024 to 13 April 2024, Mr Cauchi rented a 1.5 metre by 1.5 metre storage locker at Kennards Waterloo. On 6 March 2024, he switched to a smaller 1 metre x 1 metre unit.
- 4.33 Staff at Kennards Waterloo provided evidence regarding their observations and interactions with Mr Cauchi:
- (a) The Assistant Manager saw Mr Cauchi regularly, although their encounters were brief. Mr Cauchi was always polite, although he would only speak if spoken to and would distance himself from other customers. The Assistant Manager considered that Mr Cauchi was experiencing some mental health issues, based on his mannerisms and the way he held himself. He also always had a backpack with him.
 - (b) In early April 2024, the Assistant Manager and her own manager discussed Mr Cauchi's behaviour. She states: *"His behaviour hadn't deteriorated however he was starting to spend extended periods of time in the public bathroom on site and was consuming a lot of the tea and coffee supplies. We concluded we would just leave it for now and continue to monitor him"*.
 - (c) An Operations Manager gave evidence that his employees knew Mr Cauchi to be someone who exhibited *"really odd"* behaviour.
- 4.34 A member of the public who leased a storage locker close to Mr Cauchi's locker saw him daily in the weeks leading up to 13 April 2024 and observed that he used the washroom to wash himself and change clothes, and that on two occasions he was asleep in front of his storage locker. She concluded that he may have been experiencing homelessness.

Examination of Mr Cauchi's locker

4.35 Following the events of 13 April 2024, investigating police searched Mr Cauchi's Kennards Waterloo storage locker and located items including:

- (a) An empty KA-BAR knife box;
- (b) A four pack of Coles-branded steak knives (one knife present, three missing);
- (c) Clear resealable bags containing cannabis; and
- (d) Seven magazines (including apparently five pornographic magazines), one sketch book containing nude drawings, and two exercise books containing handwritten notes.

E. Mr Cauchi's other interactions in 2024

- 4.36 In addition to Mr Cauchi's interactions with others following his arrival in NSW in December 2023, there were also several other notable interactions in the lead up to 13 April 2024.

Interaction on 6 January 2024

- 4.37 On 5 January 2024, Mr Cauchi responded to a Facebook post made by a male who was looking for others to go surfing with him in Sydney. The man and Mr Cauchi arranged to meet the next morning at South Maroubra beach.
- 4.38 Mr Cauchi brought a large surfboard with him, which he told the man he had purchased at a pawn shop. The pair spoke while at the beach. Mr Cauchi told the man he was *"into acid and LSD"*, that he had schizophrenia and sometimes went into a psychosis, and that he did not take medication. The witness described Mr Cauchi as quiet and that *"there was something not quite right about him"*.
- 4.39 Whilst there were further exchanges of messages on 7 and 11 January 2024, Mr Cauchi did not meet up with the man again.
- 4.40 The last interaction between the man and Mr Cauchi were via messages on 8 April 2024, with Mr Cauchi sending a message to the man at 9:55am saying: *"Hi how are you? Did you want to meet up for a surf this afternoon?"*. A reply was sent from the male at 11:26am stating *"I don't have a board with me"*, to which Mr Cauchi replied, *"[y]eah no problem, do you want to meet up for a surf later in the week?"*. At 7:44pm that evening, the male replied: *"Yes just moving house atm do u know anyone with a van?"*. Mr Cauchi did not respond to this message, and they did not speak again.

Interaction on 2 April 2024

- 4.41 A few days prior to 2 April 2024, Mr Cauchi had arranged to purchase an "amp" battery that had been listed for sale on Facebook Marketplace. Mr Cauchi had messaged the seller to organise collection of the battery and was informed that he would need to collect the battery outside of work hours. Mr Cauchi told the seller he would collect it on Tuesday 2 April 2024.
- 4.42 On that evening, Mr Cauchi attended the home of the seller to collect the battery. The sellers were a couple living in Western Sydney, and Mr Cauchi arrived at their home by bus around 7:15pm.
- 4.43 Upon the female opening the door, Mr Cauchi walked inside without being invited. The female stated that she felt there was something *"not right"* about Mr Cauchi, and he was *"erratic with his arm movements when he was speaking but also appeared sheepish. He had trouble making eye contact and came across as socially awkward"*. The female's

partner, who was also present at the home, did not think Mr Cauchi was dangerous; however, he was nonetheless concerned that Mr Cauchi would return to the house and followed Mr Cauchi by car to ensure he left the area. He observed Mr Cauchi pacing back and forth while he was waiting for the bus.

Observations of Mr Cauchi at Maroubra Beach Pavilion

- 4.44 For some time prior to 13 April 2024, Mr Cauchi appears to have been sleeping rough at the Maroubra Beach Pavilion.
- 4.45 An employee of Randwick City Council states that from around Christmas 2023 until 13 April 2024, he noticed a man (Mr Cauchi) sleeping around Maroubra beach.
- 4.46 Mr Cauchi would usually pack his things into his backpack and leave between 6:00am and 6:30am daily. He observed that Mr Cauchi was generally quiet, other than on one occasion in February 2024 when Mr Cauchi appeared to be talking to himself under his breath.
- 4.47 A Team Leader at Randwick City Council organised for staff from Wesley Mission to attend Maroubra Beach to speak to Mr Cauchi.
- 4.48 On 12 April 2024, a Wesley Mission staff member attended the Maroubra Beach Pavilion, however Mr Cauchi was not there at the time.

F. Mr Cauchi's interest in and purchase of knives

4.49 On 13 April 2024, Mr Cauchi used a KA-BAR USMC knife during his attack at WBJ. It was approximately 30 centimetres in length.

4.50 Evidence was received from KA-BAR regarding the USMC model:

This knife was designed for utility use during World War II. ... The main tasks of this knife are daily functions, such as opening food rations, cutting cloth etc, while also serving in a defensive role to the user. ...

The knife, while having a USMC, marking, has not been issued by the US Military since 1945. Today, most of our sales on this particular product are out of nostalgia. This particular knife is often used as a gift or heirloom and kept in shadowboxes.

4.51 Evidence from the Australian importer and authorised distributor of this model suggests the knife has non-military uses, including camping, hunting and fishing, utility tasks, and collection and display.

Mr Cauchi's purchase of the knife used on 13 April 2024

4.52 The extensive police investigation that followed the events of 13 April 2024 established that Mr Cauchi purchased the knife used that day at a camping store in Western Sydney (**the camping store**) on 24 February 2024 at a cost of \$229.

Events leading to Mr Cauchi's knife purchase

4.53 In late February 2024, Mr Cauchi called the camping store on at least three occasions regarding the purchase of the KA-BAR knife.

4.54 Staff at the camping store recalled their interactions with Mr Cauchi, who had made enquiries via telephone asking for the "*longest*" KA-BAR knife and "*a big one*". When making enquiries by phone, staff described Mr Cauchi as "*abrupt*", "*frustrated*", "*rushed*", and he repeatedly asked "*is it the right one?*" with respect to the guidance offered by staff regarding his intended purchase of the KA-BAR.

4.55 One staff member at the camping store, who had a phone conversation with Mr Cauchi, stated that he "*seemed to be happy or excited by the tone of his voice and he did speak quickly. He seemed to know what he wanted but just couldn't really explain himself over the phone*". Due to the nature of the conversations with Mr Cauchi, staff at the camping store suggested that he attend the store in person.

Mr Cauchi attends to purchase the KA-BAR knife

4.56 On 24 February 2024, Mr Cauchi attended the camping store. The knives for sale in the camping store were locked in a secure cabinet behind the area where the cash registers

were located. The two staff members that Mr Cauchi had spoken to previously via phone were working on this date.

- 4.57 One staff member recalls that Mr Cauchi said he was a collector and was deciding between two knives, saying, “*it has to be the right one*”. The other staff member states Mr Cauchi viewed a knife that had been set aside for him and said, “*that’s the one, I really love them, I’m a collector*”. Mr Cauchi’s identity and age were confirmed by checking his licence, as per the store’s usual process, and he purchased the knife.
- 4.58 The camping store staff present that day described Mr Cauchi as being 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).

Attempted sharpening of a knife in March 2024

- 4.59 On 24 March 2024, Mr Cauchi attended a knife sharpening stall at the Marrickville Organic Food Market at Addison Road Community Centre. This was approximately three weeks prior to 13 April 2024.
- 4.60 Mr Cauchi took a KA-BAR knife from his backpack and requested it be sharpened. The stall worker advised Mr Cauchi that the knife was a “... *brand new. K-bar [sic] is a good brand; the factory edges are good... [and he didn’t] need to sharpen it.*”
- 4.61 Mr Cauchi and the stall staff member spent around 15 minutes discussing the knife. The stall worker stated that:
- [Mr Cauchi] was quite adamant that he wanted the knife sharpened. It struck me that he didn't really know that much about knives. He was happy to hear that K-bar were a good quality knife. ... Once he accepted that I was not going to sharpen the knife, I had to convince him that it didn't need sharpening.*
- 4.62 The stall worker recalls that Mr Cauchi was very well-groomed and “*a little bit strange and could be on the spectrum*” and noted that Mr Cauchi appeared “*a little bit introverted*”. He observed Mr Cauchi “*...appeared to have a bit of social anxiety, he didn’t smile or make eye contact...*” and “*...always spoke looking downwards*”.
- 4.63 On this same date, Mr Cauchi also sent a message to a knife store in Camperdown, requesting sharpening of a USMC KA-BAR. They responded to advise that they only sharpened kitchen knives.

Mr Cauchi’s prior history of knife purchases

- 4.64 Evidence obtained during the coronial investigation established that Mr Cauchi had owned several KA-BAR knives throughout his life, including the purchase outlined above on 24 February 2024.

- 4.65 The camping store that Mr Cauchi attended that day was one of a number of retail stores from the same chain. Records from that company revealed that Mr Cauchi had purchased various knives from the same chain of camping stores in Queensland and NSW.
- 4.66 Between October 2020 and February 2024, Mr Cauchi purchased the same model of knife (KA-BAR USMC knife) on four occasions: 26 October 2020, 19 July 2021 (although this was a cancelled lay-by purchase), 9 January 2023, and 24 February 2024.
- 4.67 The purchase on 9 January 2023 was the day after QPS attended the Cauchi family home on 8 January 2023 in relation to Mr Cauchi's father removing his knives (which is addressed in Part 3 of these Findings).
- 4.68 After Mr Cauchi's death, police seized Mr Cauchi's knives from the Cauchi family home. There were four KA-BAR USMC knives and one "Azero" knife. It is not known when, or from where, each of these knives was purchased (noting that Mr Cauchi's customer records from the chain of camping stores referred to above only account for a maximum of two of the knives).

The camping store policy with respect to knife sales

- 4.69 At the time of Mr Cauchi's purchase of the KA-BAR USMC knife on 24 February 2024, the camping store did not have a formal internal policy regarding sale of knives, as it was an expectation that team members would comply with knife sale regulations and legislation.
- 4.70 However, since the events of 13 April 2024, the camping store has introduced a training course in relation to Queensland knife laws and, as at April 2025, was in the process of adopting a consistent knife sale policy across all Australian states and stores.
- 4.71 It is noted that whilst the circumstances in which Mr Cauchi purchased the knife used on 13 April 2024 were considered in the Inquest, there was no further exploration of this issue.
- 4.72 On this aspect of the evidence, Counsel Assisting submitted that there is no criticism directed towards the camping store in this matter, noting that Mr Cauchi was over the age of 18 and purchased the knives legitimately. I accept that submission.

Mr Cauchi's internet activity regarding knives

- 4.73 Following the death of Mr Cauchi, police investigators seized his mobile phone and consequently were able to obtain evidence regarding his internet activity. Those enquiries revealed the following relevant evidence:
- (a) On or around 25 January 2024, Mr Cauchi recorded notes titled "to do" including "[c]all knife sharpener and confirm it doesn't need sharpening for mall use";

- (b) On 23 February 2024 and 24 March 2024, Mr Cauchi searched for terms relating to KA-BAR knives;
- (c) On 24 February 2024, Mr Cauchi took a screenshot of knife sharpening services. This was on the same date that he purchased a KA-BAR knife;
- (d) On 24 March 2024, Mr Cauchi messaged a knife store regarding sharpening a "USMC KBAR" knife (as referred to above); and
- (e) Mr Cauchi's bookmarked webpages included pages relating to military combat and the use of knives.

4.74 Mr Cauchi's interest in knives appears to have been longstanding and was previously referred to in Parts 2 and 3.

G. Police powers with respect to the possession of knives

- 4.75 A discrete issue that arose during the Inquest was the scope of police powers to search a person for knives in NSW and Queensland, and whether any changes are required in that regard.
- 4.76 Below is an overview of the current regimes. Counsel Assisting also proposed a recommendation in relation to this topic, as set out below in Section J.

Queensland and NSW

- 4.77 On 16 June 2025, “Jack’s Law”, which is named after Jack Beasley, was permanently introduced in Queensland, following a trial that commenced in May 2021.⁷⁶⁰
- 4.78 This law empowers QPS officers to use hand-held metal detectors (“wandering” devices) to detect and seize concealed weapons in certain public places under certain circumstances, which can include shopping centres or retail premises.⁷⁶¹
- 4.79 Mr Cauchi was “wanded” as part of an operation under Jack’s Law on 16 December 2023 in Broadbeach, Queensland. No weapon was detected, and the interaction was otherwise unremarkable.⁷⁶²
- 4.80 Similar laws permitting police to use hand-held metal detectors exist in both South Australia and the Northern Territory.⁷⁶³
- 4.81 In June 2024, the *Law Enforcement (Powers and Responsibilities) and Other Legislation Amendment (Knife Crime) Act 2024* (NSW) was assented to.⁷⁶⁴ As a result, Part 4A of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (**LEPRA**) was introduced, which is based on Jack’s Law.⁷⁶⁵
- 4.82 Part 4A 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.⁷⁶⁶
- 4.83 Pursuant to LEPRA, a senior police officer, that is, a police officer of or above the rank of Assistant Commissioner, has the power to declare that a particular place is a “designated area”, provided other legislative criteria are met. The area will be

⁷⁶⁰ *Police Powers and Responsibilities (Making Jack’s Law Permanent) and Other Legislation Amendment Act 2025* (Qld).

⁷⁶¹ Explanatory Note, *Police Powers and Responsibilities (Jack’s Law) Amendment Bill 2022* (Qld) at p. 1.

⁷⁶² Transcript, D6 (Quinlan): T434.23 - 29 (6 May 2025); Exhibit 1, Vol 22, Tab 819, Statement of Acting Assistant Commissioner Roger Lowe at [104]; Exhibit 1, Electronic Material, Item 43, BWV of Officer Hunt; Exhibit 1, Vol 23, Tab 862, BWV footage of Officer Hunt – Annexure A, Transcript of BWV of Officer Hunt; Exhibit 1, Vol 23, Tab 861, QPRIME Intelligence Street Check Report QI2302102131.

⁷⁶³ *Summary Offences Act 1953* (SA) Pt. 14C; *Police Administration Act 1978* (NT) Pt. VII, Div 1C.

⁷⁶⁴ *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) s 45R.

⁷⁶⁵ NSW, Parliamentary Debates, Legislative Assembly, 15 May 2024 at p. 32 (Michael Daley, Attorney General) available at: <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1323879322-141233>.

⁷⁶⁶ *Law Enforcement (Powers and Responsibilities) and Other Legislation Amendment (Knife Crime) Act 2024* (NSW) Schedule 2.

“designated” for a maximum of 12 hours. A designated area could include a shopping precinct.⁷⁶⁷

- 4.84 If a scan is undertaken and metal is detected, the person may be required to either produce the item that may be causing the alarm or resubmit to the hand-held scanner. A penalty of up to 50 units applies if the person does not comply.⁷⁶⁸
- 4.85 As at 28 January 2026, 292 declarations of a “designated area” had been made in NSW.
- 4.86 Westfield Bondi Junction (and its surrounds) was made the subject of a declaration on seven occasions as at 23 December 2025; 21 March 2025; 26 May 2025; 3 July 2025; 1 August 2025, 25 September 2025, 7 November 2025 and 27 November 2025.⁷⁶⁹

Regulation of knife sales

- 4.87 In NSW, the amendments to LEPRA set out above also introduced prohibitions on the sale of knives to a child who is 16 or 17 years of age without a “reasonable excuse”.⁷⁷⁰ There are no legal restrictions regarding the sale of KA-BAR USMC knives to adults in NSW.
- 4.88 In Queensland, new laws came into effect from 1 September 2024 which resulted in knives being classified as “controlled items”. As a result, it is unlawful for a business to sell a knife to any person aged under 18.⁷⁷¹

⁷⁶⁷ *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) ss 45F, 45I.

⁷⁶⁸ *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) ss 45M-N.

⁷⁶⁹ NSWPF, Knife Crime, available at: https://www.police.nsw.gov.au/crime/knife_crime.

⁷⁷⁰ *Law Enforcement (Powers and Responsibilities) and Other Legislation Amendment (Knife Crime) Act 2024* (NSW) Schedule 2.

⁷⁷¹ See amendments made by the *Summary Offences (Prevention of Knife Crime) and Other Legislation Amendment Act 2024* (Qld).

H. Recommendations

- 4.89 With respect to the evidence outlined in this Part, submissions were received by Counsel Assisting and Counsel on behalf of the families of the Good, Singleton and Young families regarding proposed recommendations.

Counsel Assisting's proposed recommendation – "Wandering"

- 4.90 Counsel Assisting submits that the legislative changes made in Queensland and NSW are commendable, although note that even if the complete Queensland "Jack's Law" had been operative in NSW prior to 13 April 2024, *"it is unlikely that such laws would have made any significant difference to the events which occurred on that day"*.⁷⁷²
- 4.91 Counsel Assisting submitted that a recommendation in relation to "wandering" is *"both necessary and desirable"*, in light of serious and ongoing issues caused by knife crime in the community and the potential dangers of knife crime.⁷⁷³
- 4.92 Counsel Assisting proposed a recommendation to the NSW Government in relation to wandering, which I have determined to make (as set out at the end of this Part).
- 4.93 That recommendation does not go so far as to say that the wandering-related trial should be made permanent. Instead, I recommend that the trial should be monitored and assessed, and the NSW Government should determine whether to make the trial permanent.

Families' proposed recommendation – Regulation of knife sales

- 4.94 With respect to the regulation of knife sales, Counsel Assisting did not propose a recommendation regarding a wholesale ban on the sale of KA-BAR USMC knives, given *"the various considerations that would need to be assessed before such a recommendation could be properly made"*.⁷⁷⁴
- 4.95 Counsel Assisting submitted that the KA-BAR USMC knife has legitimate uses, however it can also be deployed as a deadly weapon, and that:

... it is not proposed that there be any recommendation that the sale of KA-BAR USMC knives (or equivalents) be banned, or that the sale of such knives be the subject of stringent restrictions (for example, requiring background checks, or prohibiting their sale to people diagnosed with certain mental illnesses). This was not a topic ventilated in any detail during the Inquest. Such proposals necessarily attract a number of significant logistical, practical, and commercial considerations that would need to be

⁷⁷² Written submissions of Counsel Assisting at [2743].

⁷⁷³ Written submissions of Counsel Assisting at [2747].

⁷⁷⁴ Written submissions of Counsel Assisting at [2746].

*properly addressed before they could be sensibly made (including the consequent risk of 'black market' sales of knives).*⁷⁷⁵

- 4.96 The families of Ashlee Good, Dawn Singleton and Jade Young propose that I make a recommendation in relation to regulating knife sales, in the following terms:⁷⁷⁶

Recommendation: that the NSW Government consider implementing legislation regarding the sale of KA-BAR USMC knives, or similarly dangerous knives specially purposed for hunting, with possible features of such a regime being:

- (a) the requirement to obtain a licence to purchase and own such knives;
- (b) a waiting period between application and purchase;
- (c) psychiatric review; and/or
- (d) police record checks.

- 4.97 The families submitted that this recommendation be made for reasons including (in summary):⁷⁷⁷

- (a) The knife was a cause of the deaths on 13 April 2024, and it is significant that Mr Cauchi could purchase and use this particular type of knife;
- (b) There is no reason in principle why the sale of this type of knife (and similar types) should not be restricted in a similar way as guns are restricted in Australia (which essentially could take into account any "legitimate uses");
- (c) There should be a system in place to restrict knife ownership, in circumstances where there are reasonable grounds to suspect that the knife is being purchased for a purpose other than legitimate activities;
- (d) It is unsatisfactory that it appears the only requirement for a person to purchase a knife as at 24 February 2024 was that they show government identification;
- (e) Information such as that known to NSW Police as at 21 July 2023 regarding Mr Cauchi would have been highly relevant to whether Mr Cauchi ought to have been permitted to purchase the KA-BAR USMC knife from the camping store;
- (f) If Mr Cauchi had been required to apply for a licence prior to seeking to purchase the knife, it may (or may not) have made a causal difference, as he may have been discouraged from seeking to purchase the knife, or his application may have been refused;

⁷⁷⁵ Written submissions of Counsel Assisting at [2739].

⁷⁷⁶ Written submissions on behalf of families of Ashlee Good, Dawn Singleton and Jade Young at [7.15].

⁷⁷⁷ Written submissions on behalf of families of Ashlee Good, Dawn Singleton and Jade Young at [7.2]-[7.3], [7.7]-[7.8], [7.11], [7.13].

- (g) If Mr Cauchi only had access to a less dangerous type of knife, that may have impacted the survivability of the victims on 13 April 2024; and
- (h) There is a “*real possibility that the introduction of this requirement for a licence may make a difference in preventing, or at least reducing the likelihood or the impact of, similar events occurring in the future*”.

4.98 I have closely considered the submissions made on behalf of the families regarding a proposed recommendation with respect to knife sales.

4.99 I do not propose to make a formal recommendation with respect to the issue of knife sales, noting that it was not an area explored in Inquest and that to facilitate such a recommendation would require significant logistical, practical, and commercial conditions to be properly addressed before any such restriction on knife sales could be implemented.

4.100 However, I do note that knife crime is an area of key focus for the NSW Government. I note the submission and request of the families and encourage the NSW Government to give consideration to this issue and whether, in particular noting the submissions on behalf of the families, there is scope for further restriction or management of the sale of knives in NSW.

Recommendation

4.101 I accept the submission of Counsel Assisting that a recommendation with respect to the “wandering” powers introduced is necessary and desirable in the context of the circumstances of this matter and the prevalence of knife crime in the community.

4.102 Accordingly, I propose to make the following recommendation:

RECOMMENDATION

Recommendation 12: To the NSW Government

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 “wandering”, including whether:

- (a) Such a trial should be made permanent; or
- (b) The law should apply to certain “crowded places” without the need for a declaration to be made.

